

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
WALTER FRANKLIN ADKINS						June 13 1968			4:30 P.M.						
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	January 18, 1913		55 YRS.	MONTHS DAYS		HOURS MIN.		June 13 1968			5:20 P.M.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
Maryland			USA						WICOMICO						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury				Rt. 1, Cartwright Avenue				Tire Recapper							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland				Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. 1, Cartwright Avenue					
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last						
John			W. Adkins			Bertha			L. Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS					
No				220-10-8358		Mrs. Norma Lee Adkins, Rt. 1, Salisbury, Md.				Cartwright Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>												sudden			
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) <u>Arterio-sclerotic cardio-vascular disease</u>												years			
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
4201															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
				HOUR A.M. P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				M.D.				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				ADDRESS				June 13/1968							
Earl L. Royer, M.D.				409 Camden Ave., Salisbury, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
								ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				June 15, 1968		Wicomico Memorial Park				Salisbury, Wicomico, Maryland					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
HOLLOWAY & COMPANY, SALISBURY, MARYLAND								DATE JUN 17 1968		Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>SARAH CORNELIA ALLEN</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1968</b>			2b. HOUR <b>11:45</b> M.	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>12-05-1900</b>		6. AGE (In years lost birthday) <b>67</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.	
1d. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Tilghman</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First <b>Harry</b> Middle <b>James</b> Last		15. MOTHER'S MAIDEN NAME First <b>Belle</b> Middle <b>Cooper</b> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>213-18-1107</b>		17. INFORMANT <b>Mrs. Janice Yowell, Tilghman, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Cardiac failure 2° ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>2° to acute gastric hernia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ORI @ CVA.</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 Hrs</b> <b>40 Hrs</b> <b>2 Yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4221</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Neuvins W. Todd</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-28-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>NEUVINS W. TODD</b>				22e. ADDRESS <b>MED. CENTER, SALISBURY, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7/1/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		23d. LOCATION (City or Town) (County) (State) <b>Tilghman, Md.</b>	
24. FUNERAL DIRECTOR <b>MURICE E. NEUNAM &amp; SON, Easton, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL - 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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<div>09146</div> <div>09151</div>											
<div>09146</div> <div>09151</div>											
1. DECEASED-NAME (Type or Print)			First MARY			Middle ALBERTA			Last BAILEY		
2a. DATE KNOWN OF DEATH			Month 6			Day 29			Year 1968		
2b. HOUR			11:35			2c. DATE PRONOUNCED DEAD			Month 6		
3. SEX F			4. RACE AA			5. DATE OF BIRTH 9-19-28			6. AGE (In years last birthday) 39 YRS.		
7a. BIRTHPLACE (State or foreign country) Delaware			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Wicomico		
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) poultry work			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Del.			13b. COUNTY Sussex			13c. CITY OR TOWN Selbyville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Howard			15. MOTHER'S MAIDEN NAME Henrietta			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 221-16-8979		
17. INFORMANT Howard Bailey			ADDRESS Bridgeville, Del.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Earl L. Royer, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.			22b. DATE SIGNED July 1, 1968			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7/3/68			23c. NAME OF CEMETERY OR CREMATORY Middleford Cem.			23d. LOCATION (City or Town) (County) (State) Bridgeville, Sussex, Del.		
24. FUNERAL DIRECTOR Richard T. Watson			25a. REC'D BY REGISTRAR JUL - 3 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

• 2000-2001 •

FOR STATE  
HEALTH DEPT.

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09147 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 7a, b, Film 401 6 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First EMMA	Middle RAYNE	Last BAKER	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 6-11-68 19		2b. HOUR 8:15 PM
3. SEX F	4. RACE W	5. DATE OF BIRTH 9-1-1884		6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 6 Day 11 Year 68
7a. BIRTHPLACE (State or foreign country) Berlin, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Berlin	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Rt. 3, Box 449	
14. FATHER'S NAME First Middle Last GILLIS E. RAYNE			15. MOTHER'S MAIDEN NAME First Middle Last SALLY M. TRUITT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) NO		17. INFORMANT ADDRESS MR. EDWARD H. BAKER SNOW HILL MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 887X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Fractured left hip DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9040							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 4 XX 6-9-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell at own home.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. City or Town County State Rt. 3, Berlin, Worcester, Maryland			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED June 13, 1968
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/14/68		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WOR MD	
24. FUNERAL DIRECTOR A. Burbage Burbage Funeral Home, Berlin, Md.				25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...	

DATE	DESCRIPTION	AMOUNT	CHECK NO.	DEBIT	CREDIT	BALANCE
1974-01-01	Balance Forward					
1974-01-15	Check #1001	100.00	1001			
1974-01-20	Check #1002	200.00	1002			
1974-01-25	Check #1003	300.00	1003			
1974-02-01	Check #1004	400.00	1004			
1974-02-05	Check #1005	500.00	1005			
1974-02-10	Check #1006	600.00	1006			
1974-02-15	Check #1007	700.00	1007			
1974-02-20	Check #1008	800.00	1008			
1974-02-25	Check #1009	900.00	1009			
1974-03-01	Check #1010	1000.00	1010			
1974-03-05	Check #1011	1100.00	1011			
1974-03-10	Check #1012	1200.00	1012			
1974-03-15	Check #1013	1300.00	1013			
1974-03-20	Check #1014	1400.00	1014			
1974-03-25	Check #1015	1500.00	1015			
1974-04-01	Check #1016	1600.00	1016			
1974-04-05	Check #1017	1700.00	1017			
1974-04-10	Check #1018	1800.00	1018			
1974-04-15	Check #1019	1900.00	1019			
1974-04-20	Check #1020	2000.00	1020			
1974-04-25	Check #1021	2100.00	1021			
1974-05-01	Check #1022	2200.00	1022			
1974-05-05	Check #1023	2300.00	1023			
1974-05-10	Check #1024	2400.00	1024			
1974-05-15	Check #1025	2500.00	1025			
1974-05-20	Check #1026	2600.00	1026			
1974-05-25	Check #1027	2700.00	1027			
1974-06-01	Check #1028	2800.00	1028			
1974-06-05	Check #1029	2900.00	1029			
1974-06-10	Check #1030	3000.00	1030			
1974-06-15	Check #1031	3100.00	1031			
1974-06-20	Check #1032	3200.00	1032			
1974-06-25	Check #1033	3300.00	1033			
1974-07-01	Check #1034	3400.00	1034			
1974-07-05	Check #1035	3500.00	1035			
1974-07-10	Check #1036	3600.00	1036			
1974-07-15	Check #1037	3700.00	1037			
1974-07-20	Check #1038	3800.00	1038			
1974-07-25	Check #1039	3900.00	1039			
1974-08-01	Check #1040	4000.00	1040			
1974-08-05	Check #1041	4100.00	1041			
1974-08-10	Check #1042	4200.00	1042			
1974-08-15	Check #1043	4300.00	1043			
1974-08-20	Check #1044	4400.00	1044			
1974-08-25	Check #1045	4500.00	1045			
1974-09-01	Check #1046	4600.00	1046			
1974-09-05	Check #1047	4700.00	1047			
1974-09-10	Check #1048	4800.00	1048			
1974-09-15	Check #1049	4900.00	1049			
1974-09-20	Check #1050	5000.00	1050			
1974-09-25	Check #1051	5100.00	1051			
1974-10-01	Check #1052	5200.00	1052			
1974-10-05	Check #1053	5300.00	1053			
1974-10-10	Check #1054	5400.00	1054			
1974-10-15	Check #1055	5500.00	1055			
1974-10-20	Check #1056	5600.00	1056			
1974-10-25	Check #1057	5700.00	1057			
1974-11-01	Check #1058	5800.00	1058			
1974-11-05	Check #1059	5900.00	1059			
1974-11-10	Check #1060	6000.00	1060			
1974-11-15	Check #1061	6100.00	1061			
1974-11-20	Check #1062	6200.00	1062			
1974-11-25	Check #1063	6300.00	1063			
1974-12-01	Check #1064	6400.00	1064			
1974-12-05	Check #1065	6500.00	1065			
1974-12-10	Check #1066	6600.00	1066			
1974-12-15	Check #1067	6700.00	1067			
1974-12-20	Check #1068	6800.00	1068			
1974-12-25	Check #1069	6900.00	1069			
1974-12-31	Check #1070	7000.00	1070			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
GEORGE WILBUR BAKER SR						6 Month 21 Day 48 Year			5:50 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		CAUCASIAN		April 28, 1887		81 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Wicomico Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Salisbury, Md.			HOME - BOOTH ST.			Farmer			Own Farm
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Wicomico		Willards				xx
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Will Baker			Julia Parsons						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
xx			xx		220-17-0950 Paul Baker Berlin? Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4450 gangrene st. foot DUE TO, OR AS A CONSEQUENCE OF (b) peripheral vascular insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) generalized arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks yes yes.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 4501									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4/12, 1968, to 6/20, 1968, that (I) (we) lost saw the deceased alive on 6/19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/21/68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/23/68		Sunset Memorial Park		Berlin Worcester Md			
24. FUNERAL DIRECTOR Peter Whaley Salisbury, Del.					25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge				
					DATE JUN 24 1968				



00113

00113

UNITED STATES OF AMERICA

RECEIVED MAY 7 1964

COMMUNICATIONS

WAVE

HOME - ROUTE 35





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body after death.

VR 4-1-68  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First <b>LILLIAN</b>	Middle <b>MAE</b>	Last <b>BALL</b>	2a. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1968</b>		2b. HOUR <b>12:45 P</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6 Feb. 1911</b>		6. AGE (In years last birthday) <b>57</b> YRS.	IF UNDER 1 YEAR MONTHS <b>4</b> DAYS <b>9</b>
7a. BIRTHPLACE (State or foreign country) <b>Wicomico Co.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>WICOMICO</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>laborer- laundry</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>317 Barclay Street</b>	
14. FATHER'S NAME First <b>ELIJAH</b> Middle <b>MOORE</b> Last <b>MOORE</b>		15. MOTHER'S MAIDEN NAME First <b>CORNELIA</b> Middle <b>PHIPPIN</b> Last <b>PHIPPIN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <b>NO</b> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>221-09-1228</b>		17. INFORMANT <b>Mr. Horace W. Moore (Brother) 604 Liberty St. Salisbury, Maryland 21801</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of cervix</b> <b>180X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>171X</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>N/A</b>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>N/A</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>N/A</b>			
22a. I certify that <b>X</b> (this hospital) attended the deceased from <b>December 19, 1967</b> , to <b>June 15, 1968</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>June 15, 1968</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X)</b> (we) (did) <b>(did not)</b> view the body after death.							
22b. SIGNATURE <b>L. V. Maldve, M. D.</b>		22c. DATE SIGNED <b>6/17/68</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>19 June 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

RECEIVED MAY 12 1931

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY

FROM THE CHIEF, BUREAU OF PLANT INDUSTRY

RE: BUREAU OF PLANT INDUSTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

09150

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09155

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
ROBERTA			WALKER	BATEMAN	Month 6 Day 29 Year 1968			11:45 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		2-28-1878		90 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		U.S.A.				Wicomico			Own Home		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Riverton			Maple Side Nursing Home			House Wife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Wicomico			Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1200 Camden Ave.,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John M. Walker			Eliza Lambdin								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No						Mrs. W. Edgar Potter, Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Fracture Neck Femoral									2 years		
946X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
9629 General Arterial Sclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from April, 1965, to June 24, 1968, that (I) (we) last saw the deceased alive on June 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
J.H.S. Kuhlman									7-2-1968		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
H.S. Kuhlman			Sharptown, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		7-2-1968		Loudon Park Cemetery		Baltimore, Maryland					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Hill Funeral Home			Salisbury, Maryland			JUL - 5 1968			J. Charles Judge		

05120



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First CARL			Middle EDWARD			Last BOWDEN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year June 12 1968			2b. HOUR 5 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 15, 1903		6. AGE (in years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year June 12 1968			2d. HOUR 9:15 P.M.	
7a. BIRTHPLACE (State or foreign country) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH WICOMICO Md.				
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Market & Camden Streets				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Waterman				12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Wicomico				13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Market & Camden Streets				
14. FATHER'S NAME First Middle Last John B. Bowden						15. MOTHER'S MAIDEN NAME First Middle Last Mary Elizabeth Hall										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						(If yes give war or dates of service) War I		16b. SOCIAL SECURITY NO. 229-16-0865		17. INFORMANT (Brother) Mr. Paul Bowden, Chincoteague, Virginia				ADDRESS Beebee Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u>4109</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 2 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>																
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> <u>409 Camden Ave., Salisbury, Md.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED June 13, 1968				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE June 15, 1968		23c. NAME OF CEMETERY OR CREMATORY Mechanics Cemetery				23d. LOCATION (City or Town) (County) (State) Chincoteague, Virginia						
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge								

3510

00121





09152

09157

**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>JAY GILBERT BRADLEY</b>			2a. DATE OF DEATH Month <b>JUNE</b> Day <b>26</b> Year <b>1968</b>			2b. HOUR <b>1:58</b> PM	
3. SEX <b>Male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>12/7/1908</b>		6. AGE (In years last birthday) <b>59</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>		13b. CITY <b>WICOMICO</b>		13c. CITY OR TOWN <b>SHARPTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>312 FERRY ST.</b>		14. FATHER'S NAME First <b>AUGUSTUS G</b> Middle <b>BRADLEY</b> Last <b>BRADLEY</b>		15. MOTHER'S MAIDEN NAME First <b>ELIZABETH</b> Middle <b>TWIFORD</b> Last <b>TWIFORD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If full term or on basis of service) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>180-14-0963</b>		17. INFORMANT <b>A. Dewey Bradley, Northfield, N.J.</b>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1968</b> , to <b>June 26, 1968</b> , that (I) (we) last saw the deceased alive on <b>MAY 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thomas C. Hill Jr. MD</b>				22c. DATE SIGNED <b>June 27, 1968</b>		22d. PHYSICIAN'S NAME (Type)	
22e. ADDRESS							

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/28/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FIREMEN'S</b>		23d. LOCATION (City or Town) (County) (State) <b>SHARPTOWN, MD</b>	
24. FUNERAL DIRECTOR <b>NEWNAM FUNERAL HOME</b>		ADDRESS <b>SHARPTOWN MARYLAND</b>		25a. REC'D BY REGISTRAR <b>AUG - 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR 1-1-64  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

09153

09158

1. DECEASED-NAME (Type or print) <b>James William Bramble</b>			2a. DATE OF DEATH Month <b>6</b> Day <b>25</b> Year <b>68</b>			2b. HOUR <b>5 A M</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 16, 1897</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b>					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Waterman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Bishop's Head</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>None</b>		
14. FATHER'S NAME First <b>James</b> Middle <b>A.</b> Last <b>Bramble</b>			15. MOTHER'S MAIDEN NAME First <b>Octavia</b> Middle <b>?</b> Last <b>Bramble</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>- - -</b>			16b. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT <b>LeCompte Funeral Service records</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>Years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4200</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>May 15</b> , 19 <b>68</b> , to <b>June 25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>June 25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>A. C. Mitchell M.D.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/25/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>A. C. Mitchell, M. D.</b>						22e. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 27, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>				
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>						ADDRESS <b>Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL - 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

# CERTIFICATE OF DEATH

00166

1967

Male

White

James

VI

June 12, 1967

White

White

Married

USA

Virginia

London

England

Local and State Health

Belmont

None

Forfeited Rights of Burial

Virginia

British

British

British

James

Is on file in local records

and

---

o

Conservative home failure

Atypical for this disease

June 22, 1967

May 12

June 22

Witness

*[Signature]*

Death's cause is as follows:

D. C. Mitchell

June 27, 1967, completed the original form

Local Health Officer, New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
WILLIAM BOYD BRITTINGHAM						June 21 1968		2:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birth day)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
Male		White		April 24, 1900		68 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		USA				WICOMICO				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Route 1			Retired Mechanic				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Wicomico		Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 1	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
William Henry Brittingham			Mollie Moore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)		Address			
No			216-16-7731		Mrs. Mary Jane Brittingham		Route 1 Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Cerebral Thrombosis										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Cerebral Arteriosclerosis And										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Diabetes mellitus										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Rheumatic Heart Disease & Atrial Fibrillation										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from April 1961, to June 21, 1968, that (I) (we) last saw the deceased alive on June 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Thomas C. Hill, Jr. MD DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 24 / 1968		
22d. PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill, Jr.						22e. ADDRESS S. Salisbury Blvd., Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			June 24, 1968		Wicomico Memorial Park		Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR JUN 26 1968		25b. REGISTRAR'S SIGNATURE		



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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |   |  |  |  |
|---|--|---|--|---|---|---|--|--|--|
| 09155   |  |   |  |   | 09160   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>WALTER JASON BUTLER</b>   |  |   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>June 13 1968</b>  |   |  | 2b. HOUR<br><b>11A</b> M   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Colored</b>   |  | 5. DATE OF BIRTH<br><b>October 5, 1906</b>  |   | 6. AGE (In years last birthday)<br><b>61</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>WICOMICO</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Deer's Head State Hospital</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Day Laborer</b>                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gardener</b>                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Caroline</b>  |  | 13c. CITY OR TOWN<br><b>Preston</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>--</b>                              |  |
| 14. FATHER'S NAME First Middle Last<br><b>William W. Butler</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Bertha E. Webb</b>   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>220-09-1883</b>                           |  | 17. INFORMANT Address<br><b>E. Wesley Johns, Hurlock, Md., RFD</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pancoast's tumor of right lung with metastasis</b><br><b>1621</b> DUE TO, OR AS A CONSEQUENCE OF <b>upper thoracic vertebra</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1621 Paraplegia</b> |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |  | County State   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 10, 1968</b> , to <b>June 13, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 13, 1968</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (observe) view the body after death.   |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>C. H. Winnacott</b> DEGREE   |  |   |  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>6/13/68</b>                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>C. H. Winnacott, M. D.</b>  |  |   |  |   | 22e. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Maryland</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>June 16, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Pleasant Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Near Preston, Maryland</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>J. J. Frampton and Son, Federalburg, Md.</b>   |  |   |  |   | 25a. REC'D BY REGISTRAR<br><b>JUN 18 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |

20183

RECEIVED ON DEATH

DATE OF DEATH: 10/10/1944

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
BIRTH: [illegible]  
DEATH: [illegible]  
CAUSE: [illegible]  
MANNER: [illegible]  
PLACE: [illegible]



[Large block of illegible text, possibly a narrative or report, covering the middle section of the document.]

DATE OF DEATH: 10/10/1944  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
[Additional illegible text at the bottom of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |  |   |  |  |                                   |   |  |
|---|--|---|--|--|--|---|--|--|-----------------------------------|---|--|
| CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |                                   |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>MARGARET CANNON</b>  |  |   |  |  |  | 2a. DATE OF DEATH Month Day Year<br><b>JUNE 11, 1968</b>  |  |  | 2b. HOUR<br><b>8:15 PM</b>        |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH <b>4/18/38</b>  |  | 6. AGE (In years last birthday) <b>30</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |                                   | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Crisfield</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico Md.</b>   |  |  |                                   |   |  |
| 1d. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>SOMERSET</b>  |  | 13c. CITY OR TOWN<br><b>CRISFIELD</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  | 13e. STREET AND NUMBER<br><b>P.O. Box 135</b>                        |                                   |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Clus Cannon</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>ANNIE (CANNON)</b>  |  |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>?</b>   |  | 17. INFORMANT<br><b>PATIENT</b>   |  |  |                                   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute renal tubular necrosis &amp; sepsis</b><br><b>614X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Massive peritonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>tube-ovarian abscess</b> |  |   |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b><br><b>2 wks</b><br><b>6 mo</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>624X Pulmonary embolus &amp; infarction</b>   |  |   |  |  |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION<br><b>5-23-68</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>T-O abscess</b>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |                                   |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> or work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 3, 1968</b> , to <b>June 11, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 11, 1968</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |                                   |   |  |
| 22b. SIGNATURE<br><b>Charles S. Harrison</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |   |  |  |  | 22c. DATE SIGNED<br><b>6-11-68</b>  |  |  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |   |  |  |  | 22e. ADDRESS  |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>6/15/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESLEY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Marion Md.</b>  |  |  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Anthony E. Ward</b> ADDRESS<br><b>Crisfield Md.</b>  |  |   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 17 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Jago</b>                 |                                   |   |  |

Record

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1-17-68  
30M REV. 7-68

09157

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09162

|  |  |  |  |  |   |  |  |   |  |
|--|--|--|--|--|---|--|--|---|--|
| 1. DECEASED-NAME (Type or print) <i>Ella</i> First Middle <i>Beatrice</i> Last <i>Church</i>   |  |  | 2a. DATE OF DEATH Month <i>6</i> Day <i>6</i> Year <i>68</i>         |  |   | 2b. HOUR <i>3 P</i> M  |  |   |  |
| 3. SEX <i>7</i>  |  | 4. RACE <i>C. I.</i>   |  | 5. DATE OF BIRTH <i>Oct 8 1899</i>   |   | 6. AGE (In years last birthday) <i>68</i> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <i>Wisconsin</i> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH <i>Guantanamo</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Guantanamo</i> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>none</i>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE <i>Ind</i>  |  | 13b. COUNTY <i>Wisconsin</i>   |  | 13c. CITY OR TOWN <i>Guantanamo</i>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |
| 14. FATHER'S NAME First <i>Nathan</i> Middle <i>Jones</i> Last <i>-</i>  |  |  | 15. MOTHER'S MAIDEN NAME First <i>Lucie</i> Middle <i>Jones</i> Last |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO. <i>21205-3575</i>                           |  | 17. INFORMANT <i>Daniel Church</i> Address  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial Failure</i><br><i>4/20</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiovascular Disease</i><br>(c) <i>Hypertension; Obesity</i> |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden</i><br><i>6 months</i><br><i>None</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>443X Diabetes; Arteriosclerosis</i>   |  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 19, 1967</i> to <i>June 6, 1968</i> , that (I) (we) lost the deceased alive on <i>Sept 19, 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE <i>G. Herbert Semblay</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  | 22c. DATE SIGNED <i>June 7, 1968</i>  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <i>G. Herbert Semblay</i>   |  |  |  |  | 22e. ADDRESS <i>Salisbury Rd 21801</i>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |  | 23b. DATE <i>6-9-68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Green Acres</i>  |   | 23d. LOCATION (City or Town) (County) (State) <i>Salisbury Texas Md</i>                      |  |   |  |
| 24. FUNERAL DIRECTOR <i>Booker M West</i> ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR <i>June 11 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                      |   |  |

MEDICAL CERTIFICATION

8313

8313

RECEIVED





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |   |   |   |   |  |                                 |  |
|---|--|--|---|--|---|---|---|---|--|---------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |   |   |   |   |  |                                 |  |
| CERTIFICATE OF DEATH  |  |  |   |  |   |   |   |   |  |                                 |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>VIRGINIA   |  | Middle<br>BELL  |   | Last<br>Cluff   |   | 2a. DATE OF DEATH<br>Month<br>JUNE                       |                                 |  |
| 3. SEX<br>FEMALE  |  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>June 26, 1894   |   | 6. AGE (In years<br>last birthday)<br>74 YRS.   |   | 2b. HOUR<br>28 P.M.                                      |                                 |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Wicomico Md.  |   |  |                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Peninsula General Hospital |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>housewife |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>--               |                                 |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Somerset   |  | 13c. CITY OR TOWN<br>Rehobeth   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>Rehobeth Road                  |                                 |  |
| 14. FATHER'S NAME<br>First<br>Henry   |  |  | Middle<br>--  |  | Last<br>Young   |   | 15. MOTHER'S MAIDEN NAME<br>First<br>Rose   |   |  | Middle<br>--<br>Last<br>Wingate |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>no   |  |  | (If yes give war or dates of service)<br>--   |  | 16b. SOCIAL SECURITY NO.<br>none  |   | 17. INFORMANT<br>Address<br>Robert H. Cluff, Rehobeth, Maryland                                 |   |  |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral arteriosclerosis<br>4379<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. 354X<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br>History of Tuberculosis of Peritoneum. As heart disease |  |  |   |  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 yrs |                                 |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                         |   |   |  |                                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |  |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-22, 1968, to 6-28, 1968, that (I) (we) last<br>saw the deceased alive on 6-28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |   |   |   |   |  |                                 |  |
| 22b. SIGNATURE<br>David J. Gilmore M.D.   |  |  | 22c. DATE SIGNED  |  |   | 22d. PHYSICIAN'S<br>NAME (Type)<br>David J. Gilmore, M.D.   |   | 22e. ADDRESS<br>Salisbury, Maryland                                     |  |                                 |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>7-1-1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bethany Methodist   |   | 23d. LOCATION (City or Town) (County) (State)<br>Pocomoke City - Wor - Md.                      |   |  |                                 |  |
| 24. FUNERAL DIRECTOR<br>Robert H. Watson  |  |  | ADDRESS<br>Pocomoke City, Md.   |  |   | 25a. REC'D BY REGISTRAR<br>JUL - 5 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                             |  |                                 |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove far papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

|   |   |   |   |  |
|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Johanna CHRISTINE Collins</b>  |   | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>15</b> Year <b>1968</b>   |   | 2b. HOUR<br><b>8:45</b> M  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>December 28, 1894</b>  | 6. AGE (In years last birthday)<br><b>73</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Missouri</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House work</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Wicomico</b>  | 13c. CITY OR TOWN<br><b>Salisbury</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>Fountain Road</b>                   |
| 14. FATHER'S NAME First Middle Last<br><b>Frederick Adolf Niemoeller</b>  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Elizabeth A. Wunderlich</b>                                      |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)   | 16b. SOCIAL SECURITY NO.<br><b>-----</b>  | 17. INFORMANT (Daughter) Address <b>Fountain Road</b><br><b>Mrs. Margaret Yow, Salisbury, Maryland</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma,</b><br><b>1621</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Undifferentiated of Lung + Liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>163X</b>   |   |   |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN</b> , 19 <b>67</b> , to <b>June 15</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>June 15</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |   |   |   |  |
| 22b. SIGNATURE<br><b>Thomas C. Hill Jr. MD</b>  | 22c. DATE SIGNED<br><b>6-16-68</b>  | 22e. ADDRESS<br><b>Salisbury Blvd., Salisbury, Maryland</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>June 19, 1968</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Valhalla</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>St. Louis, Missouri</b>                     |  |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 18 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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Metastatic Carcinoma  
Lymphatic of deep fascia

James C. Hill & Co.  
244 - 245  
E-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

|   |  |   |   |   |  |   |   |   |  |  |
|---|--|---|---|---|--|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Elmer Stockley Cooper</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>16</b> Year <b>68</b>   |   |  | 2b. HOUR<br><b>3:15</b> M   |   |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>Oct. 29, 1912</b>  |  | 6. AGE (In years last birthday)<br><b>55</b> YRS.                                       |   | IF UNDER 1 YEAR<br>MONTHS OAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of last year)<br><b>Poultryman</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chickens</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |   | 13b. COUNTY <b>Worcester</b>  |   | 13c. CITY OR TOWN <b>Berlin</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>RFD # 1</b>             |  |
| 14. FATHER'S NAME First Middle Last<br><b>William S. Cooper</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Elizabeth Littleton</b>  |   |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) <b>xx</b> (If yes give year or dates of service) <b>xx</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-07-6756</b>  |   | 17. INFORMANT Address<br><b>Frances Cooper Berlin, Md. RFD # 1</b>                   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas &amp; Metastases</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>157X</b>   |  |   |   |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>5-13-68</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Probable ca pancreas</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-4</b> , 19 <b>68</b> , to <b>6-16</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6-15</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |   |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>James L. Clifford</b>  |  |   |   | 22c. DATE SIGNED<br><b>6-18-68</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>James L. Clifford</b>                                |   |   |  |  |
| 22e. ADDRESS<br><b>Medical Center Salisbury Md</b>  |  |   |   |   |  |   |   |   |  |  |
| 23a. BURIAL CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>6/18/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Hope</b>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Willards, Wicomico, Md.</b>                 |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Peter Whaley Salisbury Del.</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>JUN 21 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                      |   |   |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |                                  |   |   |
|--|----------------------------------|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                                  |   |   |
| Item# 586, Film G402 7/3/68 km   |                                  | Item# 1d, Film G402 7/2/68 km   |   |
| CERTIFICATE OF DEATH   |                                  | 09161   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Wicomico</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRUITLAND</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRUITLAND</u>   |   |
| c. LENGTH OF STAY IN lb <u>ALL LIFE</u>  |                                  | d. STREET ADDRESS <u>St. Luke Road</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>-----</u>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <u>Fred</u> First <u>Paige</u> Middle <u>Crisfield</u> Last  |                                  | 4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1968</u>  |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>N</u>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>MAY 1, 1906</u>                                     |
| 9. AGE (In years last birthday) yrs. <u>62</u>   |                                  | IF UNDER 1 YEAR Months <u>0</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>68</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>FRUITLAND</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13. FATHER'S NAME <u>Henry Paige</u>   |                                  | 14. MOTHER'S MAIDEN NAME <u>Mamie Crisfield</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>218-20-68344</u>  |                                  | 16. SOCIAL SECURITY NO. <u>MARY HUTT</u> Address <u>St. Luke Rd. Fruitland, Md</u>  |   |
| 17. INFORMANT <u>MARY HUTT</u>   |                                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma of colon + stomach</u><br>153.9 DUE TO (b) <u>Extensive metastasis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>months</u> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1992</u>  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour: a.m. <u>19</u> p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>may</u> , 19 <u>68</u> to <u>June</u> , 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>June</u> , 19 <u>68</u> and that death occurred at <u>-----</u> M, from causes and on the date stated above. |                                  |   |   |
| 22a. SIGNATURE <u>Charles S. Harrison</u>  |                                  | 22b. DATE SIGNED <u>6-19-68</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Charles S. Harrison</u>  |                                  | 22d. ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 23b. DATE THEREOF <u>6-19-68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>   | 23d. LOCATION (City or Town) (County) (State) <u>FRUITLAND Wico Md.</u> |
| 24. FUNERAL DIRECTOR <u>Loretta D. Jolley</u>  |                                  | 25a. REC'D BY REGISTRAR <u>JUN 28 1968</u>  |   |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |                                  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

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|--|--|--|---|---|---|
| 09162  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   | 09167   |   |
| Item #6, Film G401 6/24/68 km  |  |  |   |   |   |
| 1. DECEASED NAME<br>(Type or print) <b>DORSEY LEE CROPPER</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>15</b> Year <b>1968</b> |   | 2b. HOUR<br><b>11:30</b> M                                    |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>White</b>                  | 5. DATE OF BIRTH<br><b>July 11, 1898</b>   | 6. AGE (In years last birthday) <b>69</b> YRS.                        | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN                                 |
| 7a. BIRTHPLACE (State or foreign country) <b>Va</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.                             |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b>  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>General Contractor</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>  |  | 13b. COUNTY <b>Wicomico</b>  | 13c. CITY OR TOWN <b>Delmar</b>                                       | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        | 13e. STREET AND NUMBER<br><b>7 E. Elizabeth St.</b>           |
| 14. FATHER'S NAME<br>First <b>William</b> Middle <b>Cropper</b> Last <b>Amanda</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Cherrie</b> Middle <b>Delmar</b> Last <b>Md</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown   |  | 16b. SOCIAL SECURITY NO.<br><b>221-05-1824</b>   |   | 17. INFORMANT<br><b>Pluma Cropper</b> Address <b>Delmar Md</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>157.9</b> <b>Carcinoma - g.d. pancreas</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 mos</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>157X</b>  |  |  |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                     |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |
| 22b. SIGNATURE<br><b>William W. Cropper</b>  |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William W. Cropper</b>  |  | 22e. ADDRESS   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>6/18/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stephens</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>William S. Morrell</b>  |  | ADDRESS<br><b>Delmar Del</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Delmar Sussex Del.</b>  |   |
| VR A15 M<br>30M REV. 11-68   |  | 25a. REC'D BY REGISTRAR<br><b>June 19 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Charles Jones</b>   |   |



09163

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

09168

|   |  |   |   |   |  |  |   |
|---|--|---|---|---|--|--|---|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>ALBERT BENJAMIN Culver SR.</b>   |  |   | 2a. DATE OF DEATH Month Day Year<br><b>June 29 1968</b> |   |  | 2b. HOUR<br><b>4:45 AM</b>   |   |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br><b>JAN 2, 1921</b>  |  | 6. AGE (In years last birthday)<br><b>47</b> YRS.  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>DELAWARE</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>TRUCKING BUSINESS</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>DELAWARE</b>  |  | 13b. COUNTY<br><b>SUSSEX</b>  |   | 13c. CITY OR TOWN<br><b>SEAFORD</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 13e. STREET AND NUMBER<br><b>14 PORTER STREET</b>   |  | 14. FATHER'S NAME First Middle Last<br><b>MILTON L. CULVER</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>RUBY SULLIVAN JAMES</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>22-01-5284</b>   |   | 17. INFORMANT Address<br><b>ARLINE BURTOLLE CULVER SEAFORD, DEL.</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia pneumonia - hypoxia 20% sm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Auto hematemesis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Seven osteosclerotic metastatic lesions</b> |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wk</b><br><b>5-22-68</b><br><b>10 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4221</b>   |  |   |   |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>5-22-68</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ASCVD - aortic - sh</b>                                    |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-16</b> , 19 <b>68</b> , to <b>6-29</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>6-29</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |
| 22b. SIGNATURE<br><b>N. W. Todd</b>   |  |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                 |  | 22c. DATE SIGNED<br><b>6-29-68</b>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>N. W. Todd</b>   |  |   |   | 22e. ADDRESS  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>July 2, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BLADES CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BLADES DELAWARE</b>                      |   |
| 24. FUNERAL DIRECTOR<br><b>Raymond M. Watson</b>  |  |   |   | ADDRESS<br><b>SEAFORD, DEL.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JUL - 2 1968</b>   |   |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
FOR THE YEAR  
1900  
CONTAINING  
A SUMMARY OF THE  
LANDS SOLD  
AND THE  
REVENUE THEREON  
DURING THE YEAR  
1900  
AND A  
GENERAL STATEMENT  
OF THE  
LANDS  
AND  
REVENUE  
FOR THE YEAR  
1900

THE  
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FOR THE YEAR  
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REVENUE  
FOR THE YEAR  
1900



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09164

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09169

|  |               |  |  |   |  |  |  |   |                                      |   |  |                |  |
|--|---------------|--|--|---|--|--|--|---|--------------------------------------|---|--|----------------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |               | First<br>WALTER  |  | Middle<br>DALE  |  | Last<br>DALE   |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 6-13-68 <sup>19</sup> |                                      | 2b. HOUR<br>6:30 <sup>A</sup>                             |  |                |  |
| 3. SEX<br>M  | 4. RACE<br>AA | 5. DATE OF BIRTH<br>11-8-11  |  | 6. AGE (In years<br>last birthday)<br>56 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.   |                                      | 2c. DATE PRONOUNCED DEAD<br>Month 6 Day 13 Year 68        |  |                |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Wicomico   |  |   |                                      |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Pittsville  |               | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Richardson Farm |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Farmer |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |   |  |                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |               | 13b. COUNTY<br>Wicomico  |  | 13c. CITY OR TOWN<br>Pittsville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 13e. STREET AND NUMBER<br>Richardson Farm   |                                      |   |  |                |  |
| 14. FATHER'S NAME<br>First<br>Charley  |               |  |  | Middle<br>Dale  |  | Last<br>Minnie Moore   |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Minnie Moore   |                                      |   |  | Middle<br>Last |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |               | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Louise Dale Pittsville Md.  |  |   | ADDRESS                              |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic cardio-vascular disease</u> years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |               |  |  |   |  |  |  |   |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>sudden |  |                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201   |               |  |  |   |  |  |  |   |                                      |   |  |                |  |
| 19a. DATE OF OPERATION   |               |  |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |                                      |   |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |               | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |                                      |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |               | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                    |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County  |                                      | State   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |               |  |  |   |  |  |  |   |                                      |   |  |                |  |
| ACTUAL<br>SIGNATURE<br>Earl L. Royer, M.D.   |               | EXAMINER'S<br>NAME (Type)<br>409 Camden Ave., Salisbury, Md.                                       |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                      | 22b. DATE SIGNED<br>June 14, 1968                         |  |                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |               | 23b. DATE<br>6/16/1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Acres   |  | 23d. LOCATION (City or Town)<br>Salisbury  |  | (County)<br>Wicomico  |                                      | (State)<br>Md.  |  |                |  |
| 24. FUNERAL DIRECTOR<br>Clinton Stewart, Salisbury, Md.  |               |  |  | 25a. REC'D BY REGISTRAR<br>DATE JUN 19 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Young  |  |   |                                      |   |  |                |  |

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |   |  |  |
|--|---|--|--|
| 09166  |   | 09170  |  |
| 1. DECEASED-NAME (Type or print) <i>Angelina</i> First Middle Last <i>DAVIS</i>  |   |  |  |
| 2a. DATE OF DEATH <i>JUNE 26</i> Month Day Year <i>1968</i>  |   | 2b. HOUR <i>8 P</i> M  |  |
| 3. SEX <i>Female</i>   | 4. RACE <i>C NCGR</i>   | 5. DATE OF BIRTH <i>June 26-68</i>   | 6. AGE (In years last birthday) <i>—</i> YRS. <i>—</i> MONTHS <i>—</i> DAYS <i>—</i> HOURS <i>—</i> MIN <i>—</i> |
| 7a. BIRTHPLACE (State or foreign country) <i>Wicomico</i>  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <i>Wicomico</i> Md.   |
| 10. CITY OR TOWN OF DEATH <i>Salisbury</i>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>—</i>   | 12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i> COUNTY <i>Wicomico</i>   | 13b. CITY OR TOWN <i>Salisbury</i>  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER <i>410 Claborn St</i>   |
| 14. FATHER'S NAME First Middle Last <i>James Carter</i>  | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Magella Davis</i>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (na, or unknown) <i>no</i> If yes give war or dates of service  | 16b. SOCIAL SECURITY NO. <i>—</i>   | 17. INFORMANT <i>Monella Davis</i> Address <i>—</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Immaturity (Birth wt 585 gm)</i><br>7777X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>—</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>—</i> |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>approx 6 hrs</i>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>776X   |   |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/24</i> 19 <i>68</i> , to <i>6/26</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6/26</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |   |  |  |
| 22b. SIGNATURE <i>Arford C. Koltz</i> DEGREE   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED <i>6/26/68</i>  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>Medical Center Salisbury Md.</i>   | 22e. ADDRESS  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE <i>June 30-68</i>   | 23c. NAME OF CEMETERY OR CREMATORY <i>Green Acres</i>  | 23d. LOCATION (City or Town) (County) (State) <i>Salisbury MD</i>  |
| 24. FUNERAL DIRECTOR <i>Becker SM West</i> ADDRESS   | 25a. REC'D BY REGISTRAR <i>JUL - 5 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|   |  |  |   |   |   |  |  |  |  |  |
|---|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>James</i> First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month <i>JUNE</i> Day <i>27</i> Year <i>68</i>   |   |   | 2b. HOUR<br><i>5P</i> M  |  |  |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>NEGRO</i>  |   | 5. DATE OF BIRTH<br><i>June 26-68</i>   |   | 6. AGE (In years lost birthday)<br>YRS. <i>1</i> MONTHS <i>1</i> DAYS <i>16</i> HRS. <i>43</i>         |  | IF UNDER 1 YEAR<br>MONTHS <i>1</i> DAYS <i>1</i> HOURS <i>16</i> MINUTES <i>43</i> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Wisconsin</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Wisconsin Wicomico</i> Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Salisbury</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Peninsula General Hospital</i> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>none</i> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>none</i>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>   |  |  | 13b. COUNTY <i>Wicomico</i>   |   | 13c. CITY OR TOWN <i>Salisbury</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>410 Claiborne St</i>  |  |
| 14. FATHER'S NAME First Middle Last<br><i>James Carter</i>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Mayella Davis</i>  |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><i>1-20</i>   |   | 17. INFORMANT<br><i>Mayella Davis</i>   |  | Address<br><i>Wave</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Prematurity</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>776x</i>  |  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>            |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County State                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>John C. Hickey, MD</i>   |  |  |   |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>6/27/68</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>John C. Hickey, MD</i>   |  |  |   |   | 22e. ADDRESS<br><i>Penz. Genl Hosp</i>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><i>June 31-68</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Brewer Acres</i>   |   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Salisbury Md</i>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Becker M. West</i>   |  |  |   |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><i>JUL - 5 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |  |

1918



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09172

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>ELIZABETH WRIGHT DAVIS</b>   |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <b>6</b> Year <b>1968</b>  |   |  | 2b. HOUR <b>A</b> M  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>8-28-1911</b>   | 6. AGE (In years last birthday)<br><b>56</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN <input type="checkbox"/>                              | 2c. DATE PRONOUNCED DEAD<br>Month <b>6</b> Day <b>27</b> Year <b>1968</b>                  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>226 Newton St.,</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House Wife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Wicomico</b>   | 13c. CITY OR TOWN<br><b>Salisbury</b>   |   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>       | 13e. STREET AND NUMBER<br><b>226 Newton St.,</b>   |  |
| 14. FATHER'S NAME First Middle Last<br><b>E.G.B. Wright Sr.,</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Cora Downes</b>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>   |   | 17. INFORMANT ADDRESS<br><b>8076 Wilson Ave.,<br/>Mr. E.G.B. Wright Jr. Norfolk, Va. 235 18</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4129</b> hours<br><b>years</b> |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <b>19</b>                                 |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   | County   | State  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                            |  |  |   |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Dr. Earl L. Royer</b>  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br><b>6-28-1968</b>   |  |  |
| EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>   |  |  | ADDRESS (Street, city, town, or county)   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>6-29-1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parsons Cemetery</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b>                                  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Hill Funeral Home Salisbury, Maryland</b>  |  |  |   | 25a. REC'D BY REGISTRAR<br><b>JUL - 1 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                                       |  |



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "and", "the", "of" are visible.]*

*[Handwritten signature or initials in the center of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1513  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|   |  |  |                       |   |                         |   |  |  |                              |  |
|---|--|--|-----------------------|---|-------------------------|---|--|--|------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>LEONA</b> | Middle<br><b>L.</b>   | Last<br><b>DEGRUCHY</b> | 2a. DATE OF DEATH<br>Month Day Year<br><b>June 26 1968</b>                                      |  |  | 2b. HOUR<br><b>2:55 P.M.</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |                       | 5. DATE OF BIRTH<br><b>Mar. 28, 1884</b>  |                         | 6. AGE (In years<br>last birthday)<br><b>84</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                     |                              |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. COUNTY OF DEATH<br><b>WICOMICO</b>   |  |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Deer's Head State Hospital</b> |                       | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>saleswoman</b>   |                         | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>cosmetics</b>  |  |  |                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Talbot</b>   |                       | 13c. CITY OR TOWN<br><b>Easton</b>  |                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>126 North Harrison Street</b>   |                              |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Stephen Leonard</b>  |  |  |                       | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Ida Williams</b>  |                         |   |  |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>218-12-1058</b>                              |                       | 17. INFORMANT<br><b>Charles DeGruchy, R.D. #4, Box 411, Baltimore, Md.</b>  |                         |   |  |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Toxemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Gangrene of right foot</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic cardiovascular disease</b>   |  |  |                       |   |                         |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>2 months</b><br><b>Years</b> |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4221</b>   |  |  |                       |   |                         |   |  |  |                              |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                       |   |                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                              |                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |                         |   |  |  |                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                      |                       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                         |   |  |  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 14, 1967</b> , to <b>June 26, 1968</b> , that (X) (we) last<br>saw the deceased alive on <b>June 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                       |   |                         |   |  |  |                              |  |
| 22b. SIGNATURE<br><b>L. V. Maldve</b>   |  | DEGREE<br><b>M.D.</b>  |                       | ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                       |                         | 22c. DATE SIGNED<br><b>6/26/68</b>  |  |  |                              |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>L. V. Maldve, M. D.</b>   |  | 22e. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Maryland</b>   |                       |   |                         |   |  |  |                              |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>6-29-68</b>  |                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Hill Cemetery</b>   |                         | 23d. LOCATION (City or Town) (County) (State)<br><b>Easton, Talbot, Md.</b>                     |  |  |                              |  |
| 24. FUNERAL DIRECTOR<br><b>Maurice E. Neumann Sen</b>   |  |  |                       | ADDRESS<br><b>Easton, Md.</b>   |                         | 25a. REC'D BY REGISTRAR<br><b>JUL - 2 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                              |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove columns pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |  |   |  |  |  |  |  |                                   |  |
|--|--|---|--|---|--|--|--|--|--|-----------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>OTIS</b> <b>Denston</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>3</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>7:37</b> PM   |  |  |  |                                   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>AUG. 26, 1904</b>  |  | 6. AGE (In years last birthday)<br><b>63</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>AUTOMOBILE SALEMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>SOMERSET</b>  |  | 13c. CITY OR TOWN<br><b>PRINCESS ANNE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>PINE STREET</b>       |  |                                   |  |
| 14. FATHER'S NAME First Middle Last<br><b>EDWARD DENSTON</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARY TOWNSEND</b>  |  |  |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>MRS CASSIE DENSTON</b>  |  |  |  | Address<br><b>PRINCESS ANNE MARYLAND</b>           |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>severe coronary arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Approximate interval between onset and death<br><b>5 days</b><br><b>4/15</b> |  |   |  |   |  |  |  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4201 Laparotomy 6/3/68</b>  |  |   |  |   |  |  |  |  |  |                                   |  |
| 19a. DATE OF OPERATION<br><b>6/3/68</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>acute supical abdomen</b>                                  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes -</b>            |  |  |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/3</b> , 19 <b>68</b> , to <b>6/3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6/3</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |   |  |   |  |  |  |  |  |                                   |  |
| 22b. SIGNATURE<br><b>William P. Sadler M.D.</b>  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>6/4/68</b>  |  |  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |  | 22e. ADDRESS  |  |  |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>6/7/1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OLIVET CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>NEAR WEST POST, MD.</b>                  |  |  |  |                                   |  |
| 24. FUNERAL DIRECTOR<br><b>LEVIN R. WILSON</b>   |  |   |  | ADDRESS<br><b>PRINCESS ANNE, MD.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUN 10 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 09170  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 09175  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| INFANT BOY   |  |  |  |  |  |  |  |  |  | JUNE 2 68  |  |  |  |  |  |  |  |  |  | 178 M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday)                                      |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR              |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |  |  |  |  |  |
| MALE   |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | June 2, 1968   |  |  |  |  |  |  |  |  |  | X YRS.   |  |  |  |  |  |  |  |  |  | X MONTHS X DAYS X HOURS MIN. |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |  |  |  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Wicomico Md.   |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Salisbury  |  |  |  |  |  |  |  |  |  | Peninsula General Hospital   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER       |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |  |  |  |  |  |  |  | Somerset   |  |  |  |  |  |  |  |  |  | Crisfield  |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 309 N. First St.             |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Willis H. Dryden   |  |  |  |  |  |  |  |  |  | Diane Tolley   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| xxx  |  |  |  |  |  |  |  |  |  | none   |  |  |  |  |  |  |  |  |  | Willis H. Dryden, same as 13abce   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (b)  |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 777x   |  |  |  |  |  |  |  |  |  | IMMATURE, 25-26 wks gestation  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 776x   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | HOUR A.M. Month Day Year   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | P.M.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  | City or Town   |  |  |  |  |  |  |  |  |  | County                       |  |  |  |  |  |  |  |  |  | State            |  |  |  |  |  |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Street or R.F.D. No.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | DEGREE   |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| John C. Wisley   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  |  |  |  |  |  | June 3, 1968   |  |  |  |  |  |  |  |  |  | Crisfield Cemetery   |  |  |  |  |  |  |  |  |  | Crisfield - Somerset - Md.   |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Bradshaw & Sons -- Crisfield, Md.  |  |  |  |  |  |  |  |  |  | JUN 10 1968  |  |  |  |  |  |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |

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\* 101, 101, 101 - 102, 102, 102

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|--|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print) <u>WILLIAM</u> <u>DUNCAN</u>   |  |  |  |  |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 6-10-68 <sup>19</sup>   |  |  | 2b. HOUR A M  |  |  |
| 3. SEX <u>M</u>  |  | 4. RACE <u>AA</u>  |  | 5. DATE OF BIRTH <u>1893</u>   |  | 6. AGE (in years last birthday) <u>85</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____   |   | IF UNDER 24 HRS<br>HOURS _____ MIN _____       |  |
| 7a. BIRTHPLACE (State or foreign country) <u>Wicomico</u>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH <u>Wicomico</u>                          |  |  |
| 10. CITY OR TOWN OF DEATH <u>Salisbury</u>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Garner</u> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Lab</u> |   | 12b. KIND OF BUSINESS OR INDUSTRY <u>none</u>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <u>Md.</u>   |  |  |  | 13b. COUNTY <u>Wicomico</u>  |  | 13c. CITY OR TOWN <u>Salisbury</u>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 13e. STREET AND NUMBER <u>Morris Mill Road</u> |  |
| 14. FATHER'S NAME <u>unk.</u>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME <u>unk.</u>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes-no-or-unknown) <u>no</u>   |  |  |  | 16b. SOCIAL SECURITY NO. <u>---</u>  |  | 17. INFORMANT <u>John Duncan</u>   |  |  | ADDRESS   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |   |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |   |  |  |
| IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>  |  |  |  |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u>   |  |  |  |  |  |  |  |  |   |  |  |
| (b) <u>Arteriosclerotic cardio-vascular disease</u> years  |  |  |  |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |   |  |  |
| (c) _____  |  |  |  |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>   |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <u>19</u>       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. _____   |  | City or Town _____   |  | County _____   |   | State _____                                    |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |   |  |  |
| ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>  |  |  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | 22b. DATE SIGNED <u>June 14, 1968</u>                       |  |  |
| EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>  |  |  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  |
| ADDRESS (Street, city, town, or county) <u>109 Camden Ave. Salisbury, Md.</u>  |  |  |  |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE <u>6-14-68</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Not Celery Cem</u>                                   |  | 23d. LOCATION (City or town) <u>Frederick</u>  |  | (County) <u>Wicomico</u>   |   | (State) <u>Md.</u>                             |  |
| 24. FUNERAL DIRECTOR <u>Booker West, Salisbury, Md.</u>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR <u>JUN 19 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |  |  |

00174

WITHIN EXAMINED CERTIFICATE OF DEATH

78



NEW YORK STATE HEALTH DEPARTMENT  
BUREAU OF VITAL STATISTICS  
ALBANY, N. Y.

100-10-1000

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |  |  |   |   |      |  |   |   |   |  |        |  |
|---|--|---------|--|--|---|---|------|--|---|---|---|--|--------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |         |  |  |   |   |      |  |   |   |   |  |        |  |
| 1. DECEASED-NAME<br>(Type or Print)   |  |         | First  |  | Middle  |   | Last |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month Day Year |   | 2b. HOUR P M  |  |        |  |
| DONALD  |  |         | LEE  |  | DUPONT  |   |      |  | 6-9-68  |   | 19 2:20 P M   |  |        |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |      | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN.   |   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |        |  |
| M   |  | AA      |  | May 19, 1956   |   | 12 YRS.   |      |  |   |   |   | 6 9 19 68 2:20 P M                         |        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  | 9. COUNTY OF DEATH  |   |   |  |        |  |
| Maryland  |  |         | U.S.A.   |  |   |   |      |  | Wicomico Md.  |   |   |  |        |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY          |        |  |
| Salisbury   |  |         |  | Peninsula General  |   |   |      | School   |   |   |   | None                                       |        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |         |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER  |   |  |        |  |
| Md.   |  |         |  | Wicomico   |   | Salisbury   |      |  |   | Keene Ave.  |   |  |        |  |
| 14. FATHER'S NAME   |  |         | First  |  | Middle  |   | Last |  | 15. MOTHER'S MAIDEN NAME  |   |   | First Middle Last                          |        |  |
| John  |  |         | L.   |  | DuPont  |   |      |  |   | Callie  |   |  | Watson |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |         | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT   |      |  | ADDRESS   |   |   |  |        |  |
| No  |  |         |  |  |   | John DuPont   |      |  | Salisbury, Md.  |   |   |  |        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Drowning</u><br>9100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>9100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>9100</u>   |  |         |  |  |   |   |      |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes |  |        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>9298  |  |         |  |  |   |   |      |  |   |   |   |  |        |  |
| 19a. DATE OF OPERATION  |  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |   |      |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |        |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR MIN. P.M. 1:50 P.M. 6-9-68              |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Went swimming where prohibited.  |      |  |   |   |   |  |        |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Lake |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Johnson's Lake, Salisbury, Wicomico, Md.  |      |  |   |   |   |  |        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |         |  |  |   |   |      |  |   |   |   |  |        |  |
| ACTUAL SIGNATURE  |  |         | EXAMINER'S NAME (Type)   |  |   | M.D.  |      |  | 22b. DATE SIGNED  |   |   |  |        |  |
| Earl L. Royer   |  |         | 409 Camden Ave., Salisbury, Md.  |  |   |   |      |  | June 11, 1968   |   |   |  |        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                |   |      | 23d. LOCATION (City or Town) (County) (State)  |   |   |   |  |        |  |
| Burial  |  |         | 6/12/68  |  | Green Acres Cemetery                              |   |      | Salisbury Wicomico Md.   |   |   |   |  |        |  |
| 24. FUNERAL DIRECTOR  |  |         | ADDRESS  |  |   | 25a. RECD BY REGISTRAR  |      |  | 25b. REGISTRAR'S SIGNATURE  |   |   |  |        |  |
| Clinton Stewart   |  |         | Salisbury, Md.   |  |   | DATE JUN 17 1968  |      |  | Charles Judge   |   |   |  |        |  |

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|                  |  |          |  |               |  |                |  |
|------------------|--|----------|--|---------------|--|----------------|--|
| NAME             |  | LAST     |  | FIRST         |  | MIDDLE         |  |
| DATE OF BIRTH    |  | MONTH    |  | DAY           |  | YEAR           |  |
| PLACE OF BIRTH   |  | CITY     |  | STATE         |  | COUNTRY        |  |
| EDUCATION        |  | SCHOOL   |  | DEGREE        |  | YEAR           |  |
| OCCUPATION       |  | EMPLOYER |  | POSITION      |  | DATE           |  |
| MARRIAGE         |  | SPOUSE   |  | DATE          |  | PLACE          |  |
| CHILDREN         |  | NAME     |  | DATE OF BIRTH |  | PLACE OF BIRTH |  |
| MILITARY SERVICE |  | BRANCH   |  | RANK          |  | DATE           |  |
| REMARKS          |  | REASON   |  | DATE          |  | PLACE          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |  |                                   |   |
|---|--|--|--|---|---|---|--|-----------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |                                   |   |
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |                                   |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year   |  |                                   | 2b. HOUR                                    |
| George  |  |  |  | MESSICK   | Dutton  | 6 - 18 - 68   |  |                                   | 9:33 A.M.                                   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS    | IF UNDER 24 HRS.<br>HOURS MIN.              |
| Male  |  | White  |  | 02-05-85  |   | 83 YRS.   |  |                                   |   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                                   |   |
| Delaware  |  | USA.   |  |   |   | Wicomico County Md.   |  |                                   |   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)          |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| Salisbury   |  |  | Wicomico Nursing Home  |   |   | Retired Car Inspector   |  | I.R.R.                            |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER   |                                   |   |
| Delaware  |  |  | Sussex   |   | Delmar  | YES   | 610 East street  |                                   |   |
| 14. FATHER'S NAME   |  |  | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME  |  |                                   | First Middle Last                           |
| William   |  |  |  |   | Dutton  | Arabella  |  |                                   | Pettymore                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |   | Address  |                                   |   |
|   |  |  | 716-01-9439  |   | Dona L Dutton   |   | Delmar Md  |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u><br>4339<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>generalized arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>generalized arteriosclerosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 wks. |  |  |  |   |   |   |  |                                   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>332X  |  |  |  |   |   |   |  |                                   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                   |                                   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 68                |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |                                   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |                                   |   |
|   |  |  |  |   | 6/10, 1968 to 6/19, 1968  |   |  |                                   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |                                   |   |
| 22b. SIGNATURE<br>Charles Judge   |  |  |  |   | DEGREE  | ATTENDING PHYS.   | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED<br>6/18/68       |   |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   | 22e. ADDRESS  |   |  |                                   |   |
|   |  |  |  |   |   |   |  |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |   |
| Burial  |  | 3/21/68  |  | St. Stephens  |   | Delmar Sussex Del.  |  |                                   |   |
| 24. FUNERAL DIRECTOR<br>William L. Mord   |  |  |  |   | ADDRESS<br>Delmar Del.  |   | 25a. REC'D BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |
|   |  |  |  |   |   |   | DATE JUN 21 1968   |                                   |   |

General Manager

General Superintendent

Mr. C. C. W. C.

John H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |  |                                   |   |  |
|---|--|--|--|---|---|---|--|--|-----------------------------------|---|--|
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |  |                                   |   |  |
| 1. DECEASED-NAME (Type or print) <b>MYRTLE EVANS</b>  |  |  |  |   |   | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>10</b> Year <b>1968</b>   |  |  | 2b. HOUR <b>7:23</b> AM           |   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br><b>April 11, 1908</b>   |   | 6. AGE (In years last birthday) <b>60</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |                                   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b>                 |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Minn</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Wicomico Md.</b>  |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>School teacher</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>Somerset</b>  |  | 13c. CITY OR TOWN <b>Princess Anne</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  | 13e. STREET AND NUMBER <b>Irring Ave</b>       |                                   |   |  |
| 14. FATHER'S NAME First <b>Emory</b> Middle <b>Nyquist</b> Last <b>Hulda</b>  |  | 15. MOTHER'S MAIDEN NAME First <b>Holda</b> Middle <b>Anderson</b> Last <b>Anderson</b>                        |  |   |   |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown  |  |  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT <b>Irving Ave Princess Anne Md.</b>   |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1830 - Carcinoma - port. ovum</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |  |  |   |   |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr -</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1750</b>   |  |  |  |   |   |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-1, 1968</b> , to <b>6-10, 1968</b> , that (I) (we) lost saw the deceased alive on <b>6-9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |                                   |   |  |
| 22b. SIGNATURE <b>Nerins W. Todd</b> DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |   | 22c. DATE SIGNED <b>6-10-68</b>   |   |  |  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Nerins W. Todd</b>  |  |  |  |   | 22e. ADDRESS <b></b>  |   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>6/12/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Manokin</b>   |   | 23d. LOCATION (City or Town) (County) (State) <b>Princess Anne Somerset Md.</b>                               |  |  |                                   |   |  |
| 24. FUNERAL DIRECTOR <b>James L. Henne</b>  |  |  |  |   | 25a. REC'D BY REGISTRAR <b>JUN 12 1968</b>                                      |   | 25b. REGISTRAR'S SIGNATURE <b></b>                                   |  |                                   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|   |  |  |                          |   |                                      |   |  |  |                 |  |      |
|---|--|--|--------------------------|---|--------------------------------------|---|--|--|-----------------|--|------|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First                    | Middle  | Last                                 | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR<br>P M |  |      |
| John Albert Fields  |  |  |                          |   |                                      | June 6 1968   |  |  | 6:30 P M        |  |      |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH  |                                      | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |                 | IF UNDER 24 HRS.<br>HOURS MIN.                                 |      |
| male  |  | white  |                          | Oct. 1, 1893  |                                      | 74 YRS.   |  |  |                 |  |      |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. COUNTY OF DEATH  |  |  |                 |  |      |
| Maryland  |  | U.S.A.   |                          |   |                                      | Wicomico Md.  |  |  |                 |  |      |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                      | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |                 |  |      |
| Salisbury   |  | Pine Bluff State Hosp.   |                          | Farmer  |                                      |   |  |  |                 |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET AND NUMBER   |                 |  |      |
| Maryland  |  | Wicomico   |                          | Eden  |                                      |   |  |  |                 |  |      |
| 14. FATHER'S NAME   |  |  | First                    | Middle  | Last                                 | 15. MOTHER'S MAIDEN NAME  |  |  | First           | Middle   | Last |
| John Albert Fields  |  |  |                          |   |                                      | Emily - Brumbley  |  |  |                 |  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT                        |   |  |  |                 |  |      |
| no  |  |  | 213-13-5182              |   | records of Pine Bluff State Hospital |   |  |  |                 |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u><br><u>1621</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>163x</u><br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                |  |  |                          |   |                                      |   |  |  |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>unknown</u> |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Pulmonary Tuberculosis</u>  |  |  |                          |   |                                      |   |  |  |                 |  |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                 |  |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                      |   |  |  |                 |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No.  |                                      | City or Town  |  | County   |                 | State  |      |
| 22a. I certify that <u>4</u> (this hospital) attended the deceased from <u>Mar. 29</u> , 19 <u>68</u> , to <u>June 6</u> , 19 <u>68</u> , that <u>4</u> (we) last saw the deceased alive on <u>June 6</u> , 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>4</u> (we) (did) (did not) view the body after death. |  |  |                          |   |                                      |   |  |  |                 |  |      |
| 22b. SIGNATURE<br><u>E. P. Ritchings</u>  |  |  |                          |   |                                      | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>June 7, 1968</u>                              |                 |  |      |
| 22d. PHYSICIAN'S NAME (Type)<br><u>E. P. Ritchings, M.D.</u>  |  |  |                          |   |                                      | 22e. ADDRESS<br><u>Pine Bluff State Hospital</u>  |  |  |                 |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>6-9-1968</u>   |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Siloam, Cemetery</u>   |                                      | 23d. LOCATION (City or Town) (County) (State)<br><u>Siloam, Maryland</u>  |  |  |                 |  |      |
| 24. FUNERAL DIRECTOR<br><u>Hill Funeral Home, Salisbury, Maryland</u>   |  |  |                          |   |                                      | 25a. REC'D BY REGISTRAR<br>DATE <u>JUN 11 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |                 |  |      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 15-17-68  
30M REV. 1/68

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 09176  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                       |   |   |  | 09181   |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>CHARLES HENRY FITZGERALD</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>20</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>7:23 PM</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>15 Dec. 1885</b>   |  | 6. AGE (In years<br>lost birthday) <b>82</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Sussex Co. Delaware</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>WICOMICO</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>Deer's Head State Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <b>Farmer</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY <b>Farming</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>  |  | 13b. COUNTY<br><b>Wicomico</b>  |   | 13c. CITY OR TOWN<br><b>Pittsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>Sixty Foot Rd.</b>  |  | 14. FATHER'S NAME First Middle Last<br><b>JAMES FITZGERALD</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>ALICE (UNK)</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-38-8446</b>  |   | 17. INFORMANT<br><b>Mrs. Madelyn Donaway (Daughter)</b><br>(Same as Item 13 above)  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>485X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                         |  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>7-10 days</b>                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>and plate.</b><br><b>491X Intertrochanteric fracture right hip, status post-op. Smith-Petersen nail</b>   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>N/A</b>   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)<br><b>N/A</b>                     |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>N/A</b>  |  |   |  |
| 22a. I certify that <b>I</b> (this hospital) attended the deceased from <b>May 1</b> , 19 <b>68</b> , to <b>June 20</b> , 19 <b>68</b> , that <b>I</b> (we) last<br>saw the deceased alive on <b>June 20</b> , 19 <b>68</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the<br>causes stated above, <b>I</b> (we) <b>did</b> (did not) view the body after death. |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>C. H. Winnacott, M. D.</b>  |  |   |   | 22c. DATE SIGNED<br><b>6/21/68</b>  |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>C. H. Winnacott, M. D.</b>  |  |   |   | 22e. ADDRESS<br><b>Deer's Head State Hospital, Salisbury,</b>   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>June 23/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Mem. Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b>                     |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 24 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. J. Judge</b>  |  |



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

09177

09182

|   |  |   |  |   |   |  |   |  |  |  |
|---|--|---|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Neward E. Fagans</i>   |  |   | 2a. DATE OF DEATH<br>Month <i>6</i> Day <i>21</i> Year <i>68</i>             |   |   | 2b. HOUR<br>M <i></i>  |   |  |  |  |
| 3. SEX<br><i>male</i>   |  | 4. RACE<br><i>C</i>   |  | 5. DATE OF BIRTH<br><i>March 1 - 35</i>   |   | 6. AGE (In years<br>last birthday) <i>33</i> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN <i></i> |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <i>N.C.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Wicomico</i> Md.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Frederick</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <i></i>           |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <i>Labor</i> |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY <i>U.S.A.</i>                       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) <i>Frederick</i>   |  | 13b. COUNTY <i>Wicomico</i>   |  | 13c. CITY OR TOWN <i>Frederick</i>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>Poplar St</i>                               |  |  |
| 14. FATHER'S NAME First <i>James</i> Middle <i>Fagans</i> Last <i></i>  |  |   | 15. MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle <i>Blunt</i> Last <i></i> |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service) <i>No</i>   |  |   | 16b. SOCIAL SECURITY NO.<br><i>238-62-3575</i>                               |   | 17. INFORMANT <i>Sarah Fagans</i> Address <i></i>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Gastric Carcinoma</i><br><i>1519</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i></i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  |   |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>5 years</i>        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><i>151X</i>  |  |   |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i><br>P.M. <i></i> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                   |  | 21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 1, 1968</i> to <i>June 21, 1968</i> , that (I) (we) last<br>saw the deceased alive on <i>June 21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE <i>E. A. FURNELL, MD</i> DEGREE <i>MD</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED <i>22 June 68</i>  |   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>E. A. FURNELL, M.D.</i>   |  |   |  | 22e. ADDRESS <i>652 W MAIN ST, Salisbury, Md</i>  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE <i>6-25-68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Elizabeth City Cem</i>  |   | 23d. LOCATION (City or Town) <i>Elizabeth</i> (County) <i>Wic</i> (State) <i>Md</i>          |   |  |  |  |
| 24. FUNERAL DIRECTOR <i>Barker DeWitt</i> ADDRESS <i>Salisbury Md</i>   |  |   |  | 25a. REC'D BY REGISTRAR <i></i> DATE <i>JUN 25 1968</i>   |   | 25b. REGISTRAR'S SIGNATURE <i>J. J. Judge</i>  |   |  |  |  |

59160

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |                                       |   |   |   |  |  |   |  |
|--|--|---|--|---|---------------------------------------|---|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 (3)  |  |   |  |   |                                       |   |   |   |  |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  |   |                                       |   |   |   |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Doris E. Gray</b>   |  |   |  |   |                                       | 2a. DATE OF DEATH<br>Month <b>6</b> - Day <b>19</b> - Year <b>68</b>  |   |   | 2b. HOUR<br><b>12:08 PM</b>                      |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>5-14-24</b>  |                                       |   | 6. AGE (In years last birthday)<br><b>44</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>DELAWARE</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       |   | 9. COUNTY OF DEATH<br><b>Wicomico County</b> Md.  |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wicomico Nursing Home</b> |   |                                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>    |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Delaware</b>   |  |   | 13b. COUNTY<br><b>SUSSEX</b>   |   | 13c. CITY OR TOWN<br><b>Frankford</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>—</b>               |  |   |  |
| 14. FATHER'S NAME<br>First <b>ORVILLE P.</b> Middle <b>LATFIELD</b> Last <b>Sr.</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>VIOLA</b> Middle <b>LATFIELD</b> Last <b>LATFIELD</b>  |                                       |   |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-20-6742</b>  |                                       | 17. INFORMANT<br>Address <b>ORVILLE GRAY, FRANKFORD, DEL.</b>   |   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis</b><br><b>174X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma rt. breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |                                       |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 mos.</b><br><b>6 mos.</b> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>170X</b>   |  |   |  |   |                                       |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>170X</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>170X</b>                                       |  |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. <b>—</b> Month <b>—</b> Day <b>—</b> Year <b>19</b><br>P.M. <b>—</b> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |                                       |   |   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                       |   |   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/18</b> , 19 <b>68</b> , to <b>6/19</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6/18</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                                       |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Charles Judge</b>   |  |   |  |   |                                       | DEGREE<br><b>—</b>  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/20/68</b>   |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |  |   |                                       | 22e. ADDRESS  |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>6-22-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ROXANA METHODIST</b>   |                                       |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>ROXANA, SUSSEX, DELA.</b>   |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Charles Nelson, Frankford, Del.</b>   |  |   |  |   |                                       | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 25 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |   |  |

00173

OFFICE OF THE ATTORNEY GENERAL

Department of Justice  
Division of Investigation



6/2 or 6/19

John J. [illegible]

6/19



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 09179  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 09184  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  | 2a. DATE OF DEATH  |  |
| NANNIE WARD GROSS  |  |  |  |  |  | JUNE 17 1968   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  |
| FEMALE   |  | WHITE  |  | 30 July 1894   |  | 73 YRS. 10 17  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |
| West Virginia  |  | U S A  |  |  |  | Wicomico Md.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Salisbury  |  | Peninsula General Hospital   |  | Laborer-Poultry  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Maryland   |  | Wicomico   |  | Salisbury  |  | R.D.#4 Johnson Road  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  |
| James Dillion  |  | Vira Daniel  |  | No   |  | 4227-28-0194A  |  |
| 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| Mrs. Myrtle M. Brewster (Daughter)   |  | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Thrombosis</u>   |  |  |  |  |  |
| R.D.#4 Johnson Rd. Salisbury, Md. 21801  |  | (b) <u>Arteriosclerotic Cardiovascular Disease</u>   |  |  |  |  |  |
|  |  | (c) <u>4129</u>  |  |  |  |  |  |
|  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |  |  |
| 4221   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
|  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
|  |  | N/A  |  | N/A  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| N/A  |  | N/A  |  | N/A  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-9, 1968</u> , to <u>6-12, 1968</u> , that (I) (we) last saw the deceased alive on <u>6-12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |
| James L. Clifford M.D.   |  | 6-17-68  |  | James L. Clifford  |  | Medical Center Salisbury Md  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| Burial   |  | 21 June 68   |  | Parsons Cemetery   |  | Salisbury, Maryland  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| HOLLOWAY & COMPANY   |  | DATE JUN 20 1968   |  | Charles Judge  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 09185  |  |  |   |   |   |  |  |   |                                  |
|--|--|--|---|---|---|--|--|---|----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |   |  |  |   |                                  |
| Item #6, Film G402 7/3/68km  |  |  |   |   |   |  |  |   |                                  |
| CERTIFICATE OF DEATH   |  |  |   |   |   |  |  |   |                                  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last                             |   |   | 2a. DATE OF DEATH<br>Month Day Year  |  |   | 2b. HOUR                         |
| ALBERT   |  |  | DAVID   |   |   | HANIXMAN   |  |   | June 26 1968 10 <sup>55</sup> PM |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                                  |
| male   |  | white  |   | OCT 14, 1897  |   | 71 YRS.  |  |   |                                  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |   |                                  |
| Md   |  | US   |   |   |   | Wicomico Md.   |  |   |                                  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                                  |
| Salisbury  |  | Peninsula General Hospital   |   |   |   |  |  | Nurse School  |                                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |                                  |
| Md   |  | Wicomico   |   | Salisbury   |   |  |  | 215 E. dsabella St  |                                  |
| 14. FATHER'S NAME<br>First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last |   |   |  |  |   |                                  |
| David Hanixman   |  |  | Unknown                                       |   |   |  |  |   |                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.                      |   | 17. INFORMANT   |  | Address  |   |                                  |
|  |  |  | 221-07-1664                                   |   | Lena Hanixman   |  | Salisbury, Md.   |   |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>SHOCK</u><br><u>531.0</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>HEMORRHAGE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>GASTRIC ULCER</u> |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 HRS</u><br><u>48 HRS</u><br><u>4 MON'S</u> |                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>5000 ARTERIO SCLEROSIS</u>   |  |  |   |   |   |  |  |   |                                  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>YES</u> |   |                                  |
|  |  | <u>NONE</u>  |   |   |   |  |  |   |                                  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |  |  |   |                                  |
|  |  |  |   |   |   |  |  |   |                                  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |   |                                  |
|  |  |  |   |   |   |  |  |   |                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> , 19 <u>68</u> , to <u>6/26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6/26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |   |   |   |  |  |   |                                  |
| 22b. SIGNATURE<br><u>John M. Bloxom IV</u> M.D.<br>DEGREE  |  |  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>6/26/1968</u>   |   |                                  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>JOHN M. BLOXOM IV</u>   |  |  |   |   | 22e. ADDRESS<br><u>MEDICAL CENTER, SALISBURY, MD.</u>   |  |  |   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |   |                                  |
| <u>Burial</u>  |  | <u>6/24/68</u>   |   | <u>Parson Cem.</u>  |   | <u>Salisbury Wicomico Md.</u>  |  |   |                                  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |   |                                  |
| <u>William M. Ward</u>   |  | <u>Delmar Del</u>  |   | <u>JUL - 1 1968</u>   |   | <u>Charles Judge</u>   |  |   |                                  |

08220

Grade 1.1.3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |   |  |  |  |
|--|--|--|---|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |  |  |  |
| 09181 CERTIFICATE OF DEATH 09186   |  |  |   |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>BENTON MILTON HARRINGTON   |  |  | 2a. DATE OF DEATH Month Day Year<br>June 19 1968                |  |  | 2b. HOUR<br>9:40 M  |  |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>white   |   | 5. DATE OF BIRTH<br>20 Oct. 1899   |  | 6. AGE (In years last birthday)<br>68 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                        |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Wicomico Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula General Hospital |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>Auto Mechanic  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Penna.  |  | 13b. COUNTY<br>✓   |   | 13c. CITY OR TOWN<br>Philadelphia  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2088 E. Kingston Street #19134                       |  |
| 14. FATHER'S NAME First Middle Last<br>JOHN W HARRINGTON   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>JANIE ELSIE BROWN |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>182-03-7454  |   | 17. INFORMANT<br>Mrs. Lela E. Harrington (Wife) Address (Same as # 13e)  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>4310<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 days<br>Several years<br>" " |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>331X <u>Diabetes Mellitus</u>   |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br>N/A                        |   | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1968</u> , to <u>June 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>G. Herbert Sembly M.D.</u>  |  | 22c. DATE SIGNED<br><u>6/19/68</u>   |   | 22d. ADDRESS<br><u>Salisbury, Maryland 21801</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>22 June 68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Wicomico Mem. Park   |  | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Maryland                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY   |  |  |   | ADDRESS<br>SALISBURY, MARYLAND   |  | 25a. REC'D BY REGISTRAR<br>DATE JUN 21 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                             |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (5-64)  
30M REV 1/68

09182

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09187

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>SALOME CATHERINE Hartman</b>   |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>June 8 68</b>  |  | 2b. HOUR<br>Min.<br><b>4:15 AM</b>                               |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>March 8, 1876</b>  |  | 6. AGE (In years last birthday)<br><b>92</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br><b>housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Somerset</b>  | 13c. CITY OR TOWN<br><b>Westover</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 13e. STREET AND NUMBER<br><b>R.F.D. 1</b>  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Jacob -- Smith</b>   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Anna -- Kline</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>no --</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>217-54-5910</b>  | 17. INFORMANT Address<br><b>Mrs Vergie Schrock, Westover, Md.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Inflamed stomach &amp; peritonitis</b><br><b>1538</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of colon with metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>1538</b>   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>5/31</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Obstructing &amp; peritonitis</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/31</b> , 19 <b>68</b> , to <b>6/7</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Richard E. Hughes</b>   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>6/10/68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>RICHARD E. Hughes</b>   |   | 22e. ADDRESS<br><b>MEDICAL CENTER, SALISBURY, MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>6-10-1968</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Quinton Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pocomoke - Som. - Md.</b>        |  |
| 24. FUNERAL DIRECTOR<br><b>Robert H. Waban</b>   |   | ADDRESS<br><b>Pocomoke City, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUN 12 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>J. J. Judge</b>                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515  
30M. REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |   |  |  |  |   |           |  |      |
|---|--|--|--------------------------|---|--|--|--|---|-----------|--|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |   |  |  |  |   |           |  |      |
| CERTIFICATE OF DEATH  |  |  |                          |   |  |  |  |   |           |  |      |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First                    | Middle  | Last   | 2a. DATE OF DEATH  |  | 2b. HOUR                                  |           |  |      |
| HOWARD  |  |  | ISAAC                    | HENRY   |  | Month Day Year<br>June 11 1968   |  | 8:35PM                                    |           |  |      |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |           |  |      |
| Male  |  | White  |                          | December 2, 1892  |  | 75 YRS.  |  |   |           |  |      |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |           |  |      |
| Delaware  |  | USA  |                          |   |  | WICOMICO Md.   |  |   |           |  |      |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |           |  |      |
| Salisbury   |  | Peninsula General Hospital   |                          | Retired Carpenter   |  | Building   |  |   |           |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER                    |           |  |      |
| Maryland  |  | Wicomico   |                          | Salisbury   |  |  |  | Rt. 5, Old Quantico Road                  |           |  |      |
| 14. FATHER'S NAME   |  |  | First                    | Middle  | Last   | 15. MOTHER'S MAIDEN NAME   |  |   | First     | Middle                                       | Last |
| Isaac   |  |  | J.                       | Henry   |  | Mary   |  |   | Elizabeth | Hearn  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT (Niece) Address  |  |  |   |           |  |      |
| Yes War I   |  |  | 220-01-9308              |   | Mrs. Louise Polk, Salisbury, Maryland Rt. 5  |  |  |   |           |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                          |   |  |  |  |   |           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u>  |  |  |                          |   |  |  |  |   |           |  |      |
| 4129 DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |   |  |  |  |   |           |  |      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |                          |   |  |  |  |   |           | (b) <u>Generalized arteriosclerosis</u>      |      |
|   |  |  |                          |   |  |  |  |   |           | year.  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |                          |   |  |  |  |   |           |  |      |
| 4221  |  |  |                          |   |  |  |  |   |           |  |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |           |  |      |
|   |  |  |                          |   |  |  |  |   |           |  |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |           |  |      |
|   |  |  |                          |   |  |  |  |   |           |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County                                    |           | State  |      |
|   |  |  |                          |   |  |  |  |   |           |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 17, 1968</u> , to <u>June 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |   |  |  |  |   |           |  |      |
| 22b. SIGNATURE <u>Robert T. Adkins</u>  |  |  |                          |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED                          |           |  |      |
|   |  |  |                          |   |  |  |  | June 13/1968                              |           |  |      |
| 22d. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins   |  |  |                          |   |  | 22e. ADDRESS Fruitland, Maryland   |  |   |           |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |           |  |      |
| Burial  |  | June 14, 1968  |                          | Parsons Cemetery  |  | Salisbury, Wicomico, Maryland  |  |   |           |  |      |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |                          |   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                |           |  |      |
| HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |  |  |                          |   |  | DATE JUN 17 1968   |  | <u>Charles Judge</u>                      |           |  |      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115-17  
30M REV. 1/7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|   |  |  |  |   |   |   |   |                                   |  |  |        |
|---|--|--|--|---|---|---|---|-----------------------------------|--|--|--------|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year   |   |                                   | 2b. HOUR   |  |        |
| BENJAMIN FRANKLIN HURLEY  |  |  |  |   |   | June 26 1968  |   |                                   | 9 P M  |  |        |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   |   | 6. AGE (In years last birthday)   |                                   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  |        |
| Male  |  | White  |  | December 25, 1876   |   |   | 91 YRS.   |                                   | IF UNDER 24 HRS.<br>HOURS MIN.                                       |  |        |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH<br>WICOMICO Md.  |                                   |  |  |        |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |        |
| Salisbury   |  | 109 E. Locust Street   |  |   | Retired waterman  |   |   |                                   |  |  |        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER   |  |        |
| Maryland  |  |  | Wicomico   |   | Salisbury   |   | YES   |                                   | 109 E. Locust Street   |  |        |
| 14. FATHER'S NAME   |  |  | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME  |   |                                   | First  | Middle                                       | Last   |
| Unknown   |  |  |  |   |   | Shady   |   |                                   |  |  | Fisher |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   |   | 17. INFORMANT (Daughter)  |   |                                   | Address  |  |        |
| No  |  |  | 217-14-8560  |   |   | Mrs. Elsie Dean, E. St. Louis, Illinois   |   |                                   | 1049 N. 41 St.   |  |        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Stroke</u><br>2509 DUE TO, OR AS A CONSEQUENCE OF <u>Hypertensive C.V. Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Diabetes Mellitus</u><br>(b) <u>5 yrs</u><br>(c) <u>10 yrs</u> |  |  |  |   |   |   |   |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>260x  |  |  |  |   |   |   |   |                                   |  |  |        |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |                                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |        |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |                                   |  |  |        |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |                                   |  |  |        |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-10-1960</u> to <u>6/26-1968</u> , that (I) (we) saw the deceased alive on <u>6/26-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |   |                                   |  |  |        |
| 22b. SIGNATURE<br><u>W. B. Smith MD</u>   |  |  |  |   |   | 22c. DATE SIGNED<br>June 28/1968  |   |                                   | 22d. PHYSICIAN'S NAME (Type)<br>Dr. William B. Smith                 |  |        |
| 22e. ADDRESS<br>402 S. Division St., Salisbury, Maryland  |  |  |  |   |   |   |   |                                   |  |  |        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   |                                   | 23d. LOCATION (City or Town) (County) (State)                        |  |        |
| Burial  |  |  | June 29, 1968  |   |   | Wicomico Memorial Park  |   |                                   | Salisbury, Wicomico, Maryland  |  |        |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |  |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE JUL - 1 1968                                    |   |                                   | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>                |  |        |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |   |   |   |  |                                   |  |
|--|--|--|--------------------------|---|---|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |   |   |   |  |                                   |  |
| Item #1 taken from birth.cert. 09185 CERTIFICATE OF DEATH 09190  |  |  |                          |   |   |   |  |                                   |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last        |   |   | 2a. DATE OF DEATH   |  | 2b. HOUR                          |  |
| CHRISTOPHER  |  |  | TEE Lee JOHNSON          |   |   | Month Day Year<br>June 1 1968   |  | AM<br>10:30 M                     |  |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |  |
| Male   |  | White  |                          | March 14, 1968  |   | 0 YRS.  |  | MONTHS DAYS HOURS MIN.            |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Baby <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  | Md.                               |  |
| Maryland   |  | USA  |                          |   |   | WICOMICO  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Salisbury  |  | Peninsula General Hospital   |                          |   |   | None  |  | --                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET AND NUMBER            |  |
| Maryland   |  | Wicomico   |                          | Salisbury   |   |   |  | Rt. 4, Johnson Road               |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME |   |   |   |  |                                   |  |
| First Middle Last  |  |  | First Middle Last        |   |   |   |  |                                   |  |
| Louie Johnson  |  |  | Rebecca Ann Collins      |   |   |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT (Father) Rt. 4 Address Johnson Road Mr. Louie Johnson, Salisbury, Maryland  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |                          |   |   |   |  |                                   |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |                          |   |   |   |  |                                   |  |
| IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> 24 hrs   |  |  |                          |   |   |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |   |   |   |  |                                   |  |
| (b) <u>Probable stenosis of Bile Duct</u> Since Birth  |  |  |                          |   |   |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |   |   |   |  |                                   |  |
| (c) <u>Compensated D. Glority</u>  |  |  |                          |   |   |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                          |   |   |   |  |                                   |  |
| 7562   |  |  |                          |   |   |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |                                   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>March 19 68</u> , to <u>6-1-1968</u> , that (X) (we) last saw the deceased alive on <u>6-1-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |   |   |   |  |                                   |  |
| 22b. SIGNATURE <u>W B Smith</u> DECEASED   |  |  |                          |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED June 3 / 1968   |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) Dr. William B. Smith  |  |  |                          |   | 22e. ADDRESS 402 S. Division St., Salisbury, Maryland   |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  | 23b. DATE June 4, 1968   |                          | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery   |   | 23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland             |  |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |  |  |                          |   | 25a. REC'D BY REGISTRAR DATE JUN 6 1968   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>                          |                                   |  |

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RECEIVED STATE DEPARTMENT OF THE DISTRICT OF COLUMBIA

OFFICE OF THE SECRETARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |   |   |  |  |  |  |
|--|--|---|--|--|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |   |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |  |   |   |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>HAROLD WINSTON JONES, JR.</b>  |  |   |  |  |   | 2a. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>22</b> Year <b>1968</b>                   |  | 2b. HOUR <b>12:35AM</b>  |  |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>NEGRO</b>  |  | 5. DATE OF BIRTH <b>7-4-66</b>   |   | 6. AGE (In years last birthday) <b>2</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>2</b> DAYS <b>2</b> HOURS <b>2</b> MIN <b>2</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Wicomico Md.</b>  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Salisbury</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  |   | 13b. COUNTY <b>WICOMICO</b>  |  | 13c. CITY OR TOWN <b>SALISBURY</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>701 Delaware Ave</b>               |  |
| 14. FATHER'S NAME First <b>Harold</b> Middle <b>Winston</b> Last <b>Jones</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Lee</b> Last <b>Lee</b>   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT <b>Mother - Same</b> Address  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>228X mesothelioma metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>of unknown primary</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |  |   |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>227X</b>  |  |   |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE-BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 1968</b> to <b>June 21, 1968</b> , that (I) (we) saw the deceased alive on <b>June 21, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |   |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE <b>Charles S. Harrison</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |   |  | 22c. DATE SIGNED <b>6-22-68</b>  |   |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Charles S. Harrison</b>  |  |   |  | 22e. ADDRESS <b>PENINSULA GENERAL HOSPITAL</b>   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>6/26/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St Paul.</b>   |   | 23d. LOCATION (City or Town) (County) (State) <b>Revell Neck, Md</b>                    |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>William H. James Jr. Princess Anne, Md</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>Charles Judge</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |  |  |  |
|  |  |   |  | DATE <b>JUN 28 1968</b>  |   |   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09187

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09192

|  |  |   |   |   |   |   |   |  |  |   |   |  |
|--|--|---|---|---|---|---|---|--|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Esther Eunice King</i>  |  |   | 2a. DATE OF DEATH<br>Month <i>June</i> Day <i>28</i> Year <i>1968</i>                           |   |   | 2b. HOUR<br><i>9:00 PM</i>  |   |  |  |   |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br><i>Aug. 15 1897</i>   |   | 6. AGE (In years last birthday)<br><i>70</i> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i>                       |  | IF UNDER 24 HRS.<br>HOURS <i></i> MIN <i></i> |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Snow Hill Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Wicomico Md.</i>   |   |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Salisbury</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Peninsula General Hospital</i> |   |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>                               |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>                 |  |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Worcester</i>   |   | 13c. CITY OR TOWN<br><i>Snow Hill</i>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET AND NUMBER<br><i>Burnell St.</i>                         |  |   |   |  |
| 14. FATHER'S NAME<br>First <i>David</i> Middle <i>Hales</i> Last <i></i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <i>Sallie Katherine</i> Middle <i>Richardson</i> Last <i></i> |   |   |   |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, (or unknown) <i>No</i> (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.<br><i>518 30 1081</i>  |   | 17. INFORMANT<br>Address <i>Marie King Snow Hill Md.</i>        |   |   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i><br><i>4129</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4200</i><br>(b) <i></i> DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i> |  |   |   |   |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 yr</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Pleural effusion (Hemothorax)</i>  |  |   |   |   |   |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                               |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-22</i> , 19 <i>68</i> , to <i>6-28</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6-28</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |   |   |   |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><i>David F. Williams</i>   |  |   |   |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |   |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |   |   |   | 22e. ADDRESS  |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |   | 23b. DATE<br><i>July 1, 1968</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Whitcomb Methodist</i> |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Snow Hill Md.</i> |  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br><i>Roman F. Williams</i>   |  |   | ADDRESS<br><i>Snow Hill Md.</i>   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>JUL - 5 1968</i>             |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i>                |  |   |   |  |

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "00187" are visible.]*



09188

## CERTIFICATE OF DEATH

09193

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Wicomico</u><br><u>Wicomico</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>MARDELLA</u>   |  | c. LENGTH OF STAY IN 1b<br><u>3 YRS</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>MAPLE SHAD CONVALESCENT HOME</u>   |  | d. STREET ADDRESS<br><u>Bay ST</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>LENA BOWEN LAYTON</u>  |  | 4. DATE OF DEATH<br>Month <u>6</u> Day <u>8</u> Year <u>1968</u>  |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>OCT. 2, 1880</u>  |
| 9. AGE (In years last birthday)<br><u>87</u> yrs.   |  | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>BERLIN MD</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>JAMES T. BOWEN</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>LAURA A. POWELL</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u> <u>NO</u>   |  | 16. SOCIAL SECURITY NO.<br><u>—</u>   |  |
| 17. INFORMANT<br><u>MR. F. B. TURNER JR</u>   |  | Address<br><u>SALESBURY MD</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL ARTERIOSCLEROSIS</u><br>DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>—</u><br>(c) <u>—</u> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 YRS</u><br><u>5 YRS.</u>                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH<br><u>334x</u>  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> , 19 <u>68</u> , to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>9 AM</u> , from causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><u>Joseph A. Elliott</u>  |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JOSEPH A. ELLIOTT</u>  |  | 22d. ADDRESS<br><u>714 WEST ST. LAUREL, DEL.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE THEREOF<br><u>6/10/68</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>EVERGREEN</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>BERLIN MD</u>                      |
| 24. FUNERAL DIRECTOR<br><u>Anna A. Burbage</u>  |  | 25a. REC'D BY REGISTRAR<br><u>Berlin MD</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>John Judge</u>   |  | DATE<br><u>JUN 12 1968</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09194

# CERTIFICATE OF DEATH

|   |  |   |   |   |  |   |  |  |  |                                       |  |
|---|--|---|---|---|--|---|--|--|--|---------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>WILLIAM STROBEL Levy</b>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>June 29 1968</b>              |   |  | 2b. HOUR<br>M<br><b>10<sup>10</sup></b>   |  |  |  |                                       |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br><b>Oct-14-1896</b>  |  | 6. AGE (In years last birthday)<br><b>71</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>— —                                |  | IF UNDER 24 HRS.<br>HOURS MIN.<br>— — |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico Md</b>  |  |  |  |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Lawyer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Law</b>   |  |  |  |                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Wicomico</b>  |   | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Stafford Hotel, Balto. 21213</b>        |  |                                       |  |
| 14. FATHER'S NAME First Middle Last<br><b>Charles V. S. LEVY</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Grace Strobel</b> |   |  |   |  |  |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>— 7 —</b>  |   | 17. INFORMANT<br><b>Wm. W. L. Levy Jr.</b>  |  | Address<br><b>Balto. 21213</b>  |  |  |  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>486X</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>486X</b> |  |   |   |   |  |   |  |  |  |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Nephrosclerosis + generalized arteriosclerosis</b>  |  |   |   |   |  |   |  |  |  |                                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |                                       |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-29</b> , 19 <b>68</b> , to <b>6-29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6-29</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |  |                                       |  |
| 22b. SIGNATURE<br><b>David J. Palmer MD</b>   |  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |   |  | 22c. DATE SIGNED   |  |                                       |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |   |   | 22e. ADDRESS  |  |   |  |  |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>July 2/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Donnell Ridge</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville - 21208</b>                      |  |  |  |                                       |  |
| 24. FUNERAL DIRECTOR<br><b>STEWART &amp; MOWEN CO. BALTIMORE 21201</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>JUL - 2 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |                                       |  |

RECEIVED 10 MAY 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED-NAME<br>(Type or print)<br><b>ERNEST CALVIN LEWIS</b>  |   |   | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>30</b> Year <b>1968</b>                |  | 2b. HOUR<br><b>8:50PM</b>                                     |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>September 20, 1887</b>   |  | 6. AGE (In years last birthday)<br><b>80</b> YRS.                    | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>              |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>WICOMICO</b> Md.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Farmer</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>                                  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Wicomico</b>  | 13c. CITY OR TOWN<br><b>Willards</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>in village</b>                          |   |
| 14. FATHER'S NAME First <b>George</b> Middle <b>Henry</b> Last <b>Lewis</b>  |   | 15. MOTHER'S MAIDEN NAME First <b>Charlotte</b> Middle <b>Disharoon</b> Last <b>Disharoon</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>212-03-3621</b>  | 17. INFORMANT (Son) Address<br><b>Mr. Maurice L. Lewis, Willards, Maryland</b>       |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Failure</b>   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Right Cardiac Congestion</b>  |   |   |  |  | <b>3 mos.</b>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension; Arteriosclerosis</b>  |   |   |  |  | <b>????</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Hepatic Insufficiency ; Mild Diabetes</b>  |   |   |  |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)<br><b>*****</b>   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><b>*****</b>                      | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/15/68</b> , 19 <b>68</b> , to <b>6/30/68</b> , that (I) (we) last saw the deceased alive on <b>6/30/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Dr. G. Herbert Sembly</b>   |   | 22c. DATE SIGNED<br><b>July 1, 1968</b>   | 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. G. Herbert Sembly</b>                         |  |   |
| 22e. ADDRESS<br><b>400 E. Church St., Salisbury, Maryland</b>  |   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>July 3, 1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Willards Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Willards, Wicomico, Maryland</b> |  |   |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JUL - 2 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |   |

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |              |  |   |   |  |  |   |                                   |   |                                   |                                      |  |
|--|--|--------------|--|---|---|--|--|---|-----------------------------------|---|-----------------------------------|--------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |              |  |   |   |  |  |   |                                   |   |                                   |                                      |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |              | First<br>WAYNE                                   |   |   | Middle<br>ALFRED   |  |   | Last<br>LONG                      |   |                                   |                                      |  |
| 3. SEX<br>M  |  | 4. RACE<br>W |  | 5. DATE OF BIRTH<br>6-5-43  |   | 6. AGE (In years last birthday)<br>25 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   |                                   | IF UNDER 24 HRS.<br>HOURS<br>MIN.   |                                   |                                      |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Delaware  |  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA.             |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br>Wicomico    |   |                                   |                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  |              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula General |   |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Mechanic for Campbell's soup Co. |                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY |                                      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Del.  |  |              |  | 13b. COUNTY<br>Sussex   |   | 13c. CITY OR TOWN<br>Millsboro   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |                                   | 13e. STREET AND NUMBER<br>RFD 3, Box 398  |                                   |                                      |  |
| 14. FATHER'S NAME<br>Luster  |  |              | First<br>Middle<br>Long                          |   |   | 15. MOTHER'S MAIDEN NAME<br>Ethel  |  |   | First<br>Middle<br>Florence       |   |                                   | Last<br>Hudson                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>Yes   |  |              | (If yes give war or dates of service)<br>unknown |   |   | 16b. SOCIAL SECURITY NO.<br>Unknown  |  |   | 17. INFORMANT<br>Joseph B. Hudson |   |                                   | ADDRESS<br>Rt 3. Millsboro, Delaware |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fat embolism</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Fractured right femur</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hours<br>2 days                           |  |              |  |   |   |  |  |   |                                   |   |                                   |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>8254   |  |              |  |   |   |  |  |   |                                   |   |                                   |                                      |  |
| 19a. DATE OF OPERATION<br>6-23-68  |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br>Balanced traction for fracture of rt. femur  |   |  |  |   |                                   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |                                      |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/><br>2:45 P.M. 6-23-68   |  |              |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>6-23-68                                      |   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Driver of auto involved in accident.     |                                   |   |                                   |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>road              |   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Forest Grove Rd., nr. Parsonsburg, Wic., Md.                |                                   |   |                                   |                                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |              |  |   |   |  |  |   |                                   |   |                                   |                                      |  |
| ACTUAL SIGNATURE<br>Earl L. Royer, M.D.  |  |              |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |  |  | 22b. DATE SIGNED<br>June 27, 1968   |                                   |   |                                   |                                      |  |
| EXAMINER'S NAME (Type)<br>Earl L. Royer, M.D.  |  |              |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                   |   |                                   |                                      |  |
| ADDRESS (Street, city, town, or county)<br>409 Camden Ave., Salisbury, Md.   |  |              |  |   |   |  |  |   |                                   |   |                                   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |              | 23b. DATE<br>29 June 1968                        |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Millsboro Cemetery Inc. |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Millsboro, Sussex, Delaware  |                                   |   |                                   |                                      |  |
| 24. FUNERAL DIRECTOR<br>James, Millsboro, Del.   |  |              |  |   |   | 25a. REC'D BY REGISTRAR<br>JUL - 2 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |                                   |   |                                   |                                      |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon properly. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (14)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09192

CERTIFICATE OF DEATH

09197

|  |  |   |   |   |   |  |   |  |  |                               |  |
|--|--|---|---|---|---|--|---|--|--|-------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Samuel</i> First Middle Lost  |  |   | 2a. DATE OF DEATH<br>Month Day Year <i>June 6 1968</i>  |   |   | 2b. HOUR<br><i>5:35</i> AM   |   |  |  |                               |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br><i>January 27, 1898</i>   |   | 6. AGE (In years<br>lost birthday) <i>70</i> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  | IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                      |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Wicomico</i> Md.  |   |  |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Salisbury</i>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <i>Peninsula General Hospital</i> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <i>Groceryman</i> |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                     |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Wicomico</i>  |   | 13c. CITY OR TOWN<br><i>Salisbury</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><i>R.D.#6, Old Delmar Road</i> |                               |  |
| 14. FATHER'S NAME<br>First Middle Lost<br><i>Selby Burton Marvel</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br><i>Emma Jane Pusey</i>   |   |   |  |   |  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <i>No</i><br>(If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.<br><i>722-16-3328</i>  |   | 17. INFORMANT (Wife)<br><i>Mrs. Mary Lena Marvel, Salisbury, Maryland</i><br>Address <i>R.D.#6</i>  |  |   |  |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Anemia</i><br><i>284X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>2924</i><br>(b) <i>Apblei Anemia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>—</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> |  |   |   |   |   |  |   |  |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>ASCVD, Intuitive pulm. dis, obst. mopathy, perineal abscess</i>  |  |   |   |   |   |  |   |  |  |                               |  |
| 19a. DATE OF OPERATION<br><i>6-2-68</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Perineal abscess</i>     |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?               |  |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |                               |  |
| 22a. I certify that (I) (this hospital), attended the deceased from <i>5-27</i> , 19 <i>68</i> , to <i>6-6</i> , 19 <i>68</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>6-6-68</i> , 19 <i>68</i> , and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <i>we</i> ) ( <i>did</i> ) ( <i>did not</i> ) view the body after death.  |  |   |   |   |   |  |   |  |  |                               |  |
| 22b. SIGNATURE<br><i>Joseph C. Fitzgerald</i><br>22d. PHYSICIAN'S NAME (Type) <i>Dr. Joseph C. Fitzgerald</i>  |  |   |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>June 6, 1968</i>   |  |  |                               |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>June 8, 1968</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Springhill Memory Gardens</i>  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Salisbury, Wicomico, Maryland</i> |  |  |                               |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><i>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</i>  |  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>JUN 10 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                    |  |  |                               |  |

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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

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09192

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09198

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                      |   |   |  |  |  |  |
|---|----------------------|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>ROBERT WELLINGTON MCGLOTTEN, SR.</b>   |                      |   |   | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <b>6-9-68</b> 19 <b>2</b> 2b. HOUR <b>A</b> |  |  |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>AA</b> | 5. DATE OF BIRTH<br><b>6-2-10</b>   | 6. AGE (In years last birthday)<br><b>58</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   |  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN <input type="checkbox"/>              |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>              |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Sharptown</b>   |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give post address)<br><b>Sharptown, Md.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Maintenance</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |                      | 13b. COUNTY <b>Wicomico</b>   |   | 13c. CITY OR TOWN <b>Sharptown</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>Andrew W. McGlotten</b>   |                      | 15. MOTHER'S MAIDEN NAME<br><b>Sallie Quinton</b>   |   | 17. INFORMANT ADDRESS<br><b>213 03 4700 Martha McGlotten, Sharptown, Maryland</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                      | 16b. SOCIAL SECURITY NO.<br><b>213 03 4700</b>  |   | 17. INFORMANT ADDRESS<br><b>213 03 4700 Martha McGlotten, Sharptown, Maryland</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shotgun wound of abdomen</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>955X</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>        |                      |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>976X</b>   |                      |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                      | 21b. TIME OF INJURY Month, Day, Year<br><b>2</b> HOUR A.M. <b>6-9-68</b>                            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Shot self in abdomen with shotgun.</b>   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>rye field</b>    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Sharptown, Wicomico, Md.</b>  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |   |   |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Earl L. Royer, M.D.</b>  |                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | 22b. DATE SIGNED<br><b>June 11, 1968</b>   |  |
| EXAMINER'S NAME (Type)<br><b>409 Camden Ave., Salisbury, Md.</b>  |                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | ADDRESS (Street, city, town, or county)  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>6/15/68</b>   |                      | 23b. DATE<br><b>Burial</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Methodist</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Sharptown Wicomico Md.</b>               |  |
| 24. FUNERAL DIRECTOR<br><b>Mr. J.B. Dashiell, 426 Dover St., Easton, Md.</b>  |                      |   |   | 25a. REC'D BY REGISTRAR<br><b>JUN 13 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

| 09194  |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   | 09199  |  |
|--|---|---|---|--|--|
| CERTIFICATE OF DEATH   |   |   |   |  |  |
| 1. DECEASED-NAME (Type or print) <i>William James McGrath</i>  |   |   | 2a. DATE OF DEATH <i>June 15 1968</i>                             |  | 2b. HOUR <i>7A</i> M.  |
| 3. SEX <i>MALE</i>   | 4. RACE <i>White</i>                      | 5. DATE OF BIRTH <i>1 Dec. 1910</i>   |   | 6. AGE (In years last birthday) <i>57</i> YRS.   | IF UNDER 1 YEAR<br>MONTHS <i>6</i> DAYS <i>14</i><br>IF UNDER 24 HRS.<br>HOURS MIN.        |
| 7a. BIRTHPLACE (State or foreign country) <i>Salisbury</i>   | 7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <i>Wicomico</i> Md.   |  |
| 10. CITY OR TOWN OF DEATH <i>Salisbury</i>   |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>  |   | 13b. COUNTY <i>Wicomico</i>   | 13c. CITY OR TOWN <i>Salisbury</i>                                | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           | 13e. STREET AND NUMBER <i>Martin Street</i>  |
| 14. FATHER'S NAME First Middle Last <i>Charlie McGrath</i>   |   |   | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Ethel Wilkinson</i> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT <i>Mr. Robert McGrath</i> Address <i>Esther P. Hilghman</i><br><i>139 Clyde Ave. Salisbury, Maryland</i> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i><br><i>157.0</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Emphysema</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cc. Head of Pancreas</i> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4 days</i><br><i>5 yrs.</i><br><i>7</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>157x</i>  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.O. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-24, 1968</i> , to <i>6/15, 1968</i> , that (I) (we) lost saw the deceased alive on <i>6/15, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE <i>Wm B. Smith</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   |   |   | 22c. DATE SIGNED <i>6/15/68</i>  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>Dr. William B. Smith</i>   |   | 22e. ADDRESS <i>Salisbury, Maryland</i>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |   | 23b. DATE <i>June 18/68</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY <i>Shad Point Cemetery</i>  |  |
| 24. FUNERAL DIRECTOR <i>HOLLOWAY &amp; COMPANY</i>   |   | ADDRESS <i>SALISBURY, MARYLAND</i>  |   | 25a. REC'D BY REGISTRAR <i>Charles Judge</i>   |  |
| 25b. REGISTRAR'S SIGNATURE   |   | DATE <i>JUN 18 1968</i>   |   |  |  |



# FOR STATE HEALTH DEPT.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                                     |  |   |  |  |  |   |  |   |  |
|--|--|-------------------------------------|--|---|--|--|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                     |  |   |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>WICOMICO</u> MARYLAND  |  |                                     |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>  |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SALISBURY</u>   |  |                                     |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Eden MARYLAND</u>   |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>D.O.A. - Peninsula General Hospital</u>   |  |                                     |  |   |  | d. STREET ADDRESS<br><u>R.F. Di Box 161A</u>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Josephine Lee McInnis</u>  |  |                                     |  |   |  | 4. DATE OF DEATH<br>Month <u>6</u> Day <u>7</u> Year <u>1968</u>   |  |   |  |   |  |
| 5. SEX<br><u>F</u>   |  | 6. COLOR OR RACE<br><u>C</u>        |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1-10-32</u>   |  | 9. AGE (In years last birthday)<br><u>36</u> yrs. |  | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired)<br><u>LABORER</u>   |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>ARMOUR POUTRY</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>MT. VERNON Md.</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>BENJAMIN DENNIS</u>  |  |                                     |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>ETHA WINDER</u>   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |  |                                     |  | 16. SOCIAL SECURITY NO.<br><u>213-18-4099</u>   |  | 17. INFORMANT<br><u>ERIC MCINNIS</u> Address <u>R.F. Di Box 161A Eden, Md.</u>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4309</u> <u>Intu cranial hemorrhage</u><br>DUE TO (b) <u>Ruptured aneurysm of circle of Willis</u><br>DUE TO (c) <u></u>   |  |                                     |  |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>330X</u>   |  |                                     |  |   |  |  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |  |                                     |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)              |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                     |  |   |  |  |  |   |  |   |  |
| 22. ACTUAL SIGNATURE<br><u>Philip A. Insley</u> M.D.   |  |                                     |  |   |  | 22. DATE SIGNED<br><u>6-17-68</u>  |  |   |  |   |  |
| EXAMINER'S NAME (Type)<br><u>Philip A. Insley</u>  |  |                                     |  |   |  | 23. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 23b. DATE THEREOF<br><u>6-12-68</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MT. ZION</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Park Road Wico. Md.</u>  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Loretta B. Jolley R.F. Di</u>   |  |                                     |  |   |  | 25a. REC'D BY REGISTRAR<br><u>DATE JUN 18 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>James Judge</u>  |  |   |  |

two for one Film GL01 6/21/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |                                      |                                   |  |
|--|--|--|--|--|--|--|--|--|--------------------------------------|-----------------------------------|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |                                      |                                   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><i>Beulah A. Messick</i>   |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br><i>June 9 1968</i>   |  |  | 2b. HOUR<br><i>5<sup>15</sup> P.</i> |                                   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>white</i>  |  | 5. DATE OF BIRTH<br><i>7/25/1905</i>   |  | 6. AGE (In years lost birthday)<br><i>62</i> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |                                      | IF UNDER 24 HRS. HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Wicomico Md.</i>  |  |  |                                      |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Salisbury</i>  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Peninsula General Hospital</i>  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |                                      | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>  |  |  |  | 13b. COUNTY<br><i>Wicomico</i>   |  | 13c. CITY OR TOWN<br><i>Bivalve</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      | 13e. STREET AND NUMBER            |  |
| 14. FATHER'S NAME First Middle Last<br><i>James Anderson</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>—</i>   |  |  |  |  |                                      |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown<br><i>No</i>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>216-036207</i>  |  | 17. INFORMANT Address<br><i>James J. Jett, Bivalve, Md.</i>  |  |  |                                      |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |                                      |                                   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |                                      |                                   |  |
| IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i>  |  |  |  |  |  |  |  |  |                                      |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic C.V. Disease</i>  |  |  |  |  |  |  |  |  |                                      |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Not Known</i>  |  |  |  |  |  |  |  |  |                                      |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Slight CVA.</i>  |  |  |  |  |  |  |  |  |                                      |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                      |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>5/29/68</i>          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |                                      |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |                                      |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/29/68</i> , to <i>6/9/68</i> , that (I) (we) last saw the deceased alive on <i>6/9/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |                                      |                                   |  |
| 22b. SIGNATURE <i>[Signature]</i>  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <i>6/10/68</i>  |                                      |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) <i>Quartz J. Barton</i>   |  |  |  |  |  | 22e. ADDRESS <i>52156 Ave, Md.</i>   |  |  |                                      |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE <i>6/12/68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Bivalve Cem.</i>   |  | 23d. LOCATION (City or Town) (County) (State) <i>Bivalve, Md.</i>  |  |  |                                      |                                   |  |
| 24. FUNERAL DIRECTOR <i>C. Messick Bivalve, Md.</i>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR <i>JUN 12 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>  |                                      |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 09197   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   | 09202  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |
| 1. DECEASED-NAME (Type or print) <sup>First</sup> <u>Milbourne</u> <sup>Middle</sup> <u>Franklin</u> <sup>Last</sup> <u>Missick</u>   |  |  | 2a. DATE OF DEATH <sup>Month</sup> <u>June</u> <sup>Day</sup> <u>22</u> <sup>Year</sup> <u>68</u> |  | 2b. HOUR <u>3:45</u> <sup>M</sup>                              |
| 3. SEX <u>male</u>  | 4. RACE <u>white</u>                     | 5. DATE OF BIRTH <u>1/22/1882</u>  |   | 6. AGE (In years last birthday) <u>86</u> YRS.   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN         |
| 7a. BIRTHPLACE (State or foreign country) <u>MD</u>   | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <u>Wicomico</u> <sup>MD.</sup>  |  |
| 10. CITY OR TOWN OF DEATH <u>Salisbury</u>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Peninsula General Hospital</u>   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <u>Waterman</u> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>MD</u>   |  | 13b. COUNTY <u>Wicomico</u>  | 13c. CITY OR TOWN <u>Nanticoke</u>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 13e. STREET AND NUMBER   |
| 14. FATHER'S NAME <sup>First</sup> <u>William</u> <sup>Middle</sup> <u>Missick</u> <sup>Last</sup>  |  | 15. MOTHER'S MAIDEN NAME <sup>First</sup> <u>Frances</u> <sup>Middle</sup> <u>M.</u> <sup>Last</sup>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4379 Multiple Strokes</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>2nd Known</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 weeks</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>334X</u>   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <u>5/26/68</u>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/26/68</u> to <u>6/24/68</u> , that (I) (we) last saw the deceased alive on <u>6/21/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |
| 22b. SIGNATURE <u>[Signature]</u>   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                              |   | 22c. DATE SIGNED <u>6/24/68</u>  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>OSWALD J. BURTON</u>  |  | 22e. ADDRESS <u>53136th, MD</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE <u>6/24/68</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Lyonskin Cem.</u>  |  |
| 24. FUNERAL DIRECTOR <u>C. J. Messick, Div. 10, MD</u>  |  | 23d. LOCATION (City or Town) (County) (State) <u>Lyonskin, MD</u>  |   | 25a. REC'D BY REGISTRAR <u>JUN 27 1968</u>   |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 09198   |  |                              |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |        |                                      |   | 09203  |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
|---|--|------------------------------|--|--|--------|--------------------------------------|---|--|-----------------|--|-----------------------------------|--|---------|---|--|------------------------------------|--|----------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |                              |  | First  | Middle | Last                                 | 2a. DATE OF DEATH   |  |                 |  | 2b. HOUR                          |  |         |   |  |                                    |  |                            |  |
| DANIEL  |  |                              |  | LEE  |        | MORIN                                | JUNE Month 3 Day 1968 Year  |  |                 |  | 2:30 PM                           |  |         |   |  |                                    |  |                            |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |        |                                      | 6. AGE (in years last birthday)   |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS.                  |  |         |   |  |                                    |  |                            |  |
| Male  |  | White                        |  | May 31, 1968   |        |                                      | -- YRS.   |  | MONTHS          |  | DAYS                              |  |         |   |  |                                    |  |                            |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        |                                      | 9. COUNTY OF DEATH  |  |                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |         |   |  |                                    |  |                            |  |
| Maryland  |  | U.S.A.                       |  |  |        |                                      | Wicomico Md.  |  |                 |  | --                                |  |         |   |  |                                    |  |                            |  |
| 10. CITY OR TOWN OF DEATH   |  |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |        |                                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |         |   |  |                                    |  |                            |  |
| Salisbury   |  |                              |  | Peninsula General Hospital   |        |                                      | --  |  |                 |  | --                                |  |         |   |  |                                    |  |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              |  | 13b. COUNTY  |        | 13c. CITY OR TOWN                    |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                 | 13e. STREET AND NUMBER   |                                   |  |         |   |  |                                    |  |                            |  |
| Maryland  |  |                              |  | Worcester  |        | Pocomoke                             |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |                 | 402 Maple Street   |                                   |  |         |   |  |                                    |  |                            |  |
| 14. FATHER'S NAME   |  |                              |  | First  | Middle | Last                                 | 15. MOTHER'S MAIDEN NAME  |  |                 |  | First                             | Middle                                       | Last    |   |  |                                    |  |                            |  |
| Kenneth   |  |                              |  | J.   |        | Morin                                | Carol   |  |                 |  | --                                |  | Rushing |   |  |                                    |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |                              |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT Address                |   |  |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
| no  |  |                              |  | none   |        | Kenneth J. Morin, Pocomoke City, Md. |   |  |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |        |                                      |   |  |                 |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |   |  |                                    |  |                            |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disruption of Formula  |  |                              |  |  |        |                                      |   |  |                 |  |                                   | 6 hr   |         |   |  |                                    |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |        |                                      |   |  |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |                              |  |  |        |                                      |   |  |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |        |                                      |   |  |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |                              |  |  |        |                                      |   |  |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
| 921.9   |  |                              |  |  |        |                                      |   |  |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
| 19a. DATE OF OPERATION  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        |                                      |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |         |   |  |                                    |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |        |                                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |        |                                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
|   |  |                              |  |  |        |                                      |   |  |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/2, 1968, to 6/3, 1968, that (I) (we) last saw the deceased alive on 6/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |                              |  |  |        |                                      |   |  |                 |  |                                   |  |         |   |  |                                    |  |                            |  |
| 22b. SIGNATURE D. G. Anderson   |  |                              |  |  |        |                                      |   |  |                 |  |                                   | DEGREE                                       |         | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED 6/3/68            |  |                            |  |
| 22d. PHYSICIAN'S NAME (Type) D. G. Anderson, M.D.   |  |                              |  |  |        |                                      |   |  |                 |  |                                   | 22e. ADDRESS                                 |         | Medical Center, Salisbury, Md.  |  |                                    |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |   |  |                 | 23d. LOCATION (City or Town) (County) (State)                        |                                   |  |         |   |  |                                    |  |                            |  |
| Burial  |  |                              |  | 6-7-1968   |        | Yoncalla Cemetery                    |   |  |                 | Yoncalla -- Oregon   |                                   |  |         |   |  |                                    |  |                            |  |
| 24. FUNERAL DIRECTOR Robert H. Watson   |  |                              |  |  |        |                                      |   |  |                 |  |                                   | ADDRESS                                      |         | Pocomoke City, Md.  |  | 25a. REC'D BY REGISTRAR JUN 7 1968 |  | 25b. REGISTRAR'S SIGNATURE |  |

General Hospital



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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |                                    |   |   |   |   |  |
|---|---------|--|--|------------------------------------|---|---|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |                                    |   |   |   |   |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |  | First Middle Last  |                                    |   | 2a. DATE KNOWN OF DEATH   |   |   | 2b. HOUR                                     |
| KATHERINE (Katie)   |         |  | O'NEILL  |                                    |   | Month Day Year  |   |   | 1 A M  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR                    |   | IF UNDER 24 HRS   |   | 2c. DATE PRONOUNCED DEAD  |  |
| Female  | White   | May 27, 1881   | 87 YRS.  | MONTHS                             | DAYS  | HOURS   | MIN.  | Month Day Year  | 2d. HOUR                                     |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED                         |   | NEVER MARRIED   |   | 2e. COUNTY OF DEATH   |  |
| Maryland  |         | USA  |  | WIDOWED                            |   | DIVORCED  |   | WICOMICO  |  |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Parsonsborg   |         |  | Home   |                                    |   | None  |   |   | --   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. COUNTY  |                                    | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER                       |
| Maryland  |         |  | Wicomico   |                                    | Parsonsborg   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | None   |
| 14. FATHER'S NAME   |         |  | 15. MOTHER'S MAIDEN NAME   |                                    |   |   |   |   |  |
| First Middle Last   |         |  | First Middle Last  |                                    |   |   |   |   |  |
| Sylvanus J. Tilghman  |         |  | Rosa C. Lynch  |                                    |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |  | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT (Son)   |   |   |   |  |
| No  |         |  |  |                                    | 7009 Patton St. Mr. Tilghman O'Neill, Chevy Chase, Maryland                     |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |                                    |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure   |         |  |  |                                    |   |   |   |   | days   |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio-vascular disease   |         |  |  |                                    |   |   |   |   | years  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |         |  |  |                                    |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |  |                                    |   |   |   |   |  |
| 4221  |         |  |  |                                    |   |   |   |   |  |
| 19a. DATE OF OPERATION  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                    |   |   |   | 20. AUTOPSY?  |  |
|   |         |  |  |                                    |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         |  | 21b. TIME OF INJURY Month, Day, Year   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |   |  |
|   |         |  | HOUR A.M. P.M.   |                                    | 19  |   |   |   |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |  |  |                                    |   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |  |                                    |   |   |   |   |  |
| ACTUAL SIGNATURE  |         |  | CHIEF MEDICAL EXAMINER   |                                    |   | 22b. DATE SIGNED  |   |   |  |
| EXAMINER'S NAME (Type)  |         |  | M.D. ASSISTANT MEDICAL EXAMINER  |                                    |   | June 17 / 1968  |   |   |  |
| Earl L. Royer, M.D.   |         |  | DEPUTY MEDICAL EXAMINER  |                                    |   | June 17 / 1968  |   |   |  |
| 409 Camden Ave., Salisbury, Md.   |         |  | ADDRESS (Street, city, town, or county)                                      |                                    |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)   |   |   |  |
| Burial  |         | June 17, 1968  |  | Parsonsborg Cemetery               |   | Parsonsborg, Wicomico, Maryland   |   |   |  |
| 24. FUNERAL DIRECTOR  |         |  | 25a. REC'D BY REGISTRAR  |                                    |   | 25b. REGISTRAR'S SIGNATURE  |   |   |  |
| HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |         |  | DATE JUN 18 1968   |                                    |   | Charles Judge   |   |   |  |

2252



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |  |   |  |
|---|--|---|--|---|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |  |   |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>THOMAS</b> <b>W.</b> <b>OUTTEN</b>   |  |   |  |   | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>25</b> Year <b>1968</b>                |   | 2b. HOUR<br><b>1245AM</b>  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Nov. 30, 1892</b>  |  | 6. AGE (In years lost birthday)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>WICOMICO</b> Md.   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Deer's Head State Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Farmer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Worcester</b>   |  | 13c. CITY OR TOWN<br><b>Pocomoke</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Rt. #3, Box 214</b>   |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>William Thomas Outten</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Lydia -- Mumford</b>   |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b>  |  | (If yes give war or dates of service)<br><b>--</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-36-0108</b>  |  | 17. INFORMANT Address<br><b>Mrs Nettie Outten, Pocomoke, Md.</b>                                |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive pulmonary embolus</b><br><b>4120</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertensive arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hours</b> |  |   |  |   |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>443x Cerebral thrombosis with right hemiplegia</b>   |  |   |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 12, 1968</b> , to <b>June 25, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 25, 1968</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <b>not</b> view the body after death.                   |  |   |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>C. H. Winnacott, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Maryland</b>  |  | 22c. DATE SIGNED<br><b>6/25/68</b>  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY  |  | 23d. LOCATION (City or Town) (County) (State) |  |
|   |  | <b>Burial</b>   |  | <b>6-27-1968</b>  |  | <b>Remson Methodist</b>   |  | <b>Pocomoke - Wor. - Md.</b>   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert H. Watson</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUN 28 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
30M REV. 1-68

09201

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09206

# CERTIFICATE OF DEATH

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED-NAME<br>(Type or print) <b>JOHN</b> <b>EDGAR</b> <b>PARKER</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>9</b> Year <b>1968</b>     |  | 2b. HOUR<br><b>4:15 AM</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>                    | 5. DATE OF BIRTH<br><b>June 24, 1903</b>  |  | 6. AGE (In years last birthday)<br><b>64</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>DAYS<br>HOURS<br>MIN.                |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>WICOMICO</b> Md.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b>   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Employee</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Wicomico</b>  | 13c. CITY OR TOWN<br><b>Salisbury</b>                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 13e. STREET AND NUMBER<br><b>202 Walston Avenue</b>                                   |
| 14. FATHER'S NAME<br>First <b>Nutter</b> Middle <b>John</b> Last <b>Parker</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Lucy</b> Middle <b>Anna</b> Last <b>Shockley</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b><br>(If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>214-10-7318A</b>   | 17. INFORMANT (Wife)<br><b>Mrs. Leona M. Parker, Salisbury, Maryland</b> |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b><br><b>YRS.</b>           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                            |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/8</b> <b>June 8, 1968</b> to <b>6/9</b> <b>June 9, 1968</b> , that (I) (we) last saw the deceased alive on <b>6/8</b> <b>June 8, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                             |  |   |  |  |   |
| 22b. SIGNATURE<br><b>E. M. Beardsley</b>   |  | DEGREE<br><b>Dr. E. M. Beardsley</b>  |  | 22c. DATE SIGNED<br><b>June 10 / 1968</b>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. E. M. Beardsley</b>   |  | 22e. ADDRESS<br><b>211 Maryland Ave., Salisbury, Maryland</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>June 12, 1968</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>      |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Wicomico, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>   |  |   | 25a. REC'D BY REGISTRAR<br><b>JUN 13 1968</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                    |

MEDICAL CERTIFICATION

10933

myocardial infarction  
generalized arteriosclerosis

10/1  
1/2

12 June 22 1/2

1/2  
F. B. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-141  
30M REV. 1/68

| MARTLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>Item #6, Film 401 6/27/68km   |  |  |  |   |  |   |  |                                   |  |
|---|--|--|--|---|--|---|--|-----------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year   |  |                                   | 2b. HOUR   |
| LILLIE  |  |  | WILLEY   | PHILLIPS  | June 15 1968   |   |  | 12:25 PM                          |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  |
| Female  |  | White  |  | Sept. 27, 1886  |  | 81 82 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN     |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   | Md.  |
| Maryland  |  | USA  |  |   |  | WICOMICO  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Salisbury   |  |  | Deer's Head State Hospital   |   |  | Housewife   |  | Home                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. CITY OR TOWN  |   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET AND NUMBER   |                                   |  |
| Maryland  |  |  | Dorchester   |   | Cambridge  |   | 1004 Washington Street   |                                   |  |
| 14. FATHER'S NAME   |  |  | First  | Middle  | Last   | 15. MOTHER'S MAIDEN NAME  |  |                                   | First Middle Last                                      |
| George Henry Willey   |  |  |  |   |  | Dorothy ? Shorter   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |   |  |                                   |  |
| No  |  |  | unk  |   | LeCompte Funeral Service records   |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>485X</u> <u>Bronehopneumonia, right base</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>49X</u> <u>Old cerebral thrombosis; diabetes mellitus</u>  |  |  |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |                                   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 26, 1963</u> , to <u>June 15</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) lost <input checked="" type="checkbox"/> saw the deceased alive on <u>June 15</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <u>XXXX</u> view the body after death. |  |  |  |   |  |   |  |                                   |  |
| 22b. SIGNATURE <u>L. V. Maldve</u>  |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>6/17/68  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>L. V. Maldve, M. D.   |  |  |  |   | 22e. ADDRESS<br>Deer's Head State Hospital, Salisbury, Md  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |
| Burial  |  | June 18, 1968  |  | Dorchester Memorial Park  |  | Cambridge, Maryland   |  |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>LeCompte Funeral Service, Cambridge, Maryland   |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE JUN 24 1968  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                     |                                   |  |

U. S. DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C.

Serial 1000  
Date 10/10/1918

U. S. ARMY  
OFFICE OF THE ADJUTANT GENERAL

Serial 1000  
Date 10/10/1918

U. S. ARMY  
OFFICE OF THE ADJUTANT GENERAL

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Serial 1000  
Date 10/10/1918

U. S. ARMY  
OFFICE OF THE ADJUTANT GENERAL



1  
90  
22  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |  |                          |                               |  |
|--|--|---|--|---|--|--|--|--|--------------------------|-------------------------------|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |                          |                               |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>LIZZIE COLLIER POTTER</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>6 27 1968</b>  |  |  | 2b. HOUR<br><b>2P. M</b> |                               |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>11-10-1879</b>   |  | 6. AGE (In years last birthday)<br><b>88</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |                          | IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |  |  |                          |                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Spring Hill Sanitarium</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House Wife</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                 |                          |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Wicomico</b>  |  | 13c. CITY OR TOWN<br><b>Salisbury</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>W. William &amp; Poplar Hill Ave</b>    |                          |                               |  |
| 14. FATHER'S NAME First Middle Last<br><b>Levin D. Collier</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Louisa Bratten</b>   |  |  |  |  |                          |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) <b>no</b><br>(If yes give war or dates of service) -----   |  | 16b. SOCIAL SECURITY NO.<br>-----   |  | 17. INFORMANT Address<br><b>E. Dale Adkins, Salisbury, Maryland</b>   |  |  |  |  |                          |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac degeneration</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pericardial Hyp</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>mons</b><br><b>4 yrs.</b> |  |   |  |   |  |  |  |  |                          |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4222</b>   |  |   |  |   |  |  |  |  |                          |                               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                          |                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |                          |                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |                          |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |                          |                               |  |
| 22b. SIGNATURE<br><b>MA Briele</b>   |  |   |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6-28-1968</b>                                 |                          |                               |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MA Briele</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>Salisbury, Maryland</b>   |  |  |                          |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>6-29-1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parsons Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b>  |  |  |                          |                               |  |
| 24. FUNERAL DIRECTOR<br><b>Hill, Funeral Home Salisbury, Maryland</b>  |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL - 1 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                 |                          |                               |  |

3382

3382

Eastern Department  
February 1949

Mr. Up  
Mr. Biddle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |   |   |   |  |  |   |  |  |
|---|--|--|---|---|---|---|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |   |   |   |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |   |   |   |   |   |  |  |   |  |  |
| 1. DECEASED-NAME (Type or print) <b>Robert Hilton Powell</b>  |  |  |   |   |   | 2a. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>18</b> Year <b>1968</b>   |   |  | 2b. HOUR <b>11:25</b> M                              |   |  |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>White</b>   |   | 5. DATE OF BIRTH<br><b>9 Nov. 1915</b>  |   | 6. AGE (In years last birthday)<br><b>52</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b>7</b> DAYS <b>9</b>                     |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Wicomico</b>   |   |  | Md.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Driver Lumber Co.</b>             |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Wicomico</b>  |   | 13c. CITY OR TOWN<br><b>Salisbury</b>                                       |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>809 S. Division St.</b> |   |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>WILLIAM HENRY POWELL</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>LIDA PUSEY</b>   |   |   |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-05-3678</b>  |   | 17. INFORMANT<br><b>Mrs. Gladys M. Powell (Wife)</b><br>(Same as #13 above) |   |   | Address  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109</b> <b>CORONARY Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>coronary atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>generalized arteriosclerosis</b>                                     |  |  |   |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>2 years</b><br><b>years -</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b> <b>Hypercholesterolemia</b>  |  |  |   |   |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                          |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>N/A</b>   |   |   |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><b>N/A</b> |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>N/A</b>  |   |   |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>60</b> , to <b>June</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>1 June</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Robert T. Adkins M.D.</b>  |  |  |   |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>18 June 68</b>                                |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Robert Adkins</b>  |  |  |   |   |   | 22e. ADDRESS<br><b>Fruitland, Maryland</b>  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>21 June 68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Mem. Park</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b>   |   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY</b>   |  |  |   | ADDRESS<br><b>SALISBURY, MARYLAND</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 21 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |   |  |  |

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(M)

Wisconsin

Penitentiary General Hospital

Penitentiary

Penitentiary General Hospital

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |  |  |  |  |
| 09205   |  |  |   |  |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |  |
| 09210   |  |  |   |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>VERA Hope POWERS  |  |  |   |  | 2a. DATE OF DEATH Month Day Year<br>June 28, 1968  |  |  | 2b. HOUR<br>1:10 P.M.                                      |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>Jan. 5, 1931   |  | 6. AGE (In years last birthday)<br>37 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Wicomico Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula General Hospital |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Teacher |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>High School           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>MARYLAND   |  | 13b. COUNTY<br>Worcester   |   | 13c. CITY OR TOWN<br>Snow Hill   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br>Circle Drive                     |  |
| 14. FATHER'S NAME First Middle Last<br>Ira Herman POWERS  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Vera Maudie WELSH |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>Unknown  |   | 17. INFORMANT Address<br>Sgt. Chas. C. Powers, Fort Bragg N.C.   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis<br>5770<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4-5 days   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>5870   |  |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                    |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                       |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/24, 1968, to 6/28, 1968, that (I) (we) last saw the deceased alive on JUNE 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br>William B. Long   |  |  |   | 22c. DATE SIGNED<br>6/28/68  |  | 22d. PHYSICIAN'S NAME (Type)<br>M.D. DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |
| 22e. ADDRESS  |  |  |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>July 2, 1968  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Grove Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Morgantown W. Va  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Thomas F. Williams  |  | ADDRESS<br>Snow Hill Md  |   | 25a. REC'D BY REGISTRAR<br>JUL - 1 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |  |  |

100-100000

100-100000



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VR 3 (1-68)  
30M REV. 7/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><i>William T. Pruitt</i>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><i>June 14 68</i>            |   |  | 2b. HOUR<br><i>11 45 M</i>  |  |  |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br><i>MAR. 3 - 1888</i>  |  | 6. AGE (In years lost birthday)<br><i>80</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>VIRGINIA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Wicomico Md.</i>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Salisbury</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Peninsula General Hospital</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Waterman</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>VIRGINIA</i>   |  | 13b. COUNTY<br><i>Accomack</i>  |   | 13c. CITY OR TOWN<br><i>TANGLIER ISLAND</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>MAIN ROAD.</i>                      |  |
| 14. FATHER'S NAME First Middle Last<br><i>STEPHEN PRUITT</i>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>JULIA WILLIAMS</i> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown (If yes give war or dates of service)<br><i>YES RESERVE AIRBORNE</i>   |  |   | 16b. SOCIAL SECURITY NO.<br><i>UNKNOWN</i>                          |   | 17. INFORMANT<br><i>VIRGINIA WATERS</i>  |   | Address<br><i>21545 ORIOLE MD</i>                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Perforated abdominal aortic aneurysm</i><br><i>4412</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>ASCVD</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>36 hrs</i>                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)<br><i>451X</i>   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>6/13/68</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Perf. abd aortic aneurysm</i>                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)<br><i>451X</i>  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/13, 1968</i> to <i>6/14, 1968</i> , that (I) (we) last saw the deceased alive on <i>6/14, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>W. Scovill M.D.</i>   |  |   |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><i>6/14/68</i>                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>William A. Scovill M.D.</i>   |  |   |   |   | 22e. ADDRESS<br><i>Peninsula Gen Hosp</i>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>6-17-68</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>SUNNYRIDGE Cem.</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>CRISFIELD Sunny MD</i>                      |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Harman F. Horne</i>   |  |   |   |   | 25a. REC'D BY REGISTRAR<br><i>Harman F. Horne</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                   |  |  |
|  |  |   |   |   | DATE<br><i>JUN 19 1968</i>   |   |  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |               |   |   |   |  |   |  |   |   |  |
|--|---------------|---|---|---|--|---|--|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |               |   |   |   |  |   |  |   |   |  |
| 1. DECEASED-NAME (Type or Print) First Middle Last<br>MARGARET BEATHER QUILLEN   |               |   |   |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year<br>6-23-68 19 10:55 |   |  | 2b. HOUR A  |   |  |
| 3. SEX<br>F  | 4. RACE<br>AA | 5. DATE OF BIRTH<br>4-7-05  | 6. AGE (In years last birthday)<br>63 YRS.        | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.                       |  | 2c. DATE PRONOUNCED DEAD<br>Month 6 Day 23 Year 68 10:55                            |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND  |               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |  | 9. COUNTY OF DEATH<br>Wicomico Md.                  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |               | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula General |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)        |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Pa.   |               |   | 13b. COUNTY<br>Chester                            |   | 13c. CITY OR TOWN<br>Philadelphia  |   | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>6123 Spruce St. |  |
| 14. FATHER'S NAME First Middle Last<br>Isaac Scholfield  |               |   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Margaret K. Brittingham   |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown)   |               |   | 16b. SOCIAL SECURITY NO.<br>211-16-9292           |   | 17. INFORMANT<br>Daniel Quillen 6123 Spruce St. Phila, Pa.                                     |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |               |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>sudden                              |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201   |               |   |   |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |               |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |               | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |               | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                      |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County State  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |               |   |   |   |  |   |  |   |   |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)   |               | Earl L. Royer, M.D.<br>409 Camden Ave., Salisbury, Md   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br>June 24, 1968                   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |               | BURIAL  |   | 23b. DATE<br>6-29-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rolling Green |  | 23d. LOCATION (City or Town) (County) (State)<br>Phila Md.                          |   |  |
| 24. FUNERAL DIRECTOR<br>Jolley Funeral Home, Salisbury, Md.  |               |   |   | 25a. REC'D BY REGISTRAR<br>JUN 28 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge         |  |   |   |  |

0350



100

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                              |  |  |   |   |   |  |  |  |
|--|---------|------------------------------|--|--|---|---|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                              |  |  |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First  |  | Middle  |   | Last  |  | 2a. DATE KNOWN OF DEATH                            | 2b. HOUR                                     |
| ELIJAH   |         |                              | SAVAGE   |  |   |   |   |  | <input checked="" type="checkbox"/> Month Day Year | L:18 P:M                                     |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS.  |   | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR                                     |
| M  | AA      | 11/10/1901                   | 67 YRS.  | MONTHS   | DAYS  | HOURS   | MIN.  | Month 6 Day 18 Year 1968   | L:18 P:M   |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |  |  |  |
| P  |         | U.S.                         |  |  |   | Wicomico Md.  |   |  |  |  |
| 1d. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |
| Salisbury  |         |                              | Peninsula General  |  |   | LABORER   |   |  | FARM   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |
| Md.  |         |                              | Worcester  |  |   | Pocomoke  |   |  |  |  |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |  |   |   |   |  |  |  |
| First Middle Last  |         |                              | First Middle Last  |  |   |   |   |  |  |  |
| Unknown  |         |                              | Unknown  |  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT   |   | ADDRESS  |  |  |
|  |         |                              |  |  |   | Employer - ISAAC DORSEY   |   | Crisfield Md.  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |         |                              |  |  |   |   |   |  |  | days   |
| IMMEDIATE CAUSE (a) Sub-dural hematoma, right  |         |                              |  |  |   |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |  |   |   |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |                              |  |  |   |   |   |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |  |   |   |   |  |  |  |
| (c)  |         |                              |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |  |   |   |   |  |  |  |
| 9035   |         |                              |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |   |   | 2D. AUTOPSY?  |  |  |  |
|  |         |                              |  |  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                              | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |  |  |  |
|  |         |                              | HOUR A.M. P.M.   |  | Fell on street.   |   |   |  |  |  |
| 21d. INJURY OCCURRED   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |                              | street   |  | Westover, Somerset, Md.   |   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                              |  |  |   |   |   |  |  |  |
| ACTUAL SIGNATURE   |         |                              | M.D.   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |  | 22b. DATE SIGNED                                   |  |
| EXAMINER'S NAME (Type)   |         |                              | Earl L. Royer, F.D.  |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                     |   |  | June 20, 1968                                      |  |
| NAME (Type)  |         |                              | 409 Camden Ave., Salisbury, Md.  |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                             |   |  | ADDRESS (Street, city, town, or county)            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                       |  |  |  |
| Burial   |         |                              | 6/25/68  |  | Asbury  |   | Crisfield Md  |  |  |  |
| 24. FUNERAL DIRECTOR   |         |                              |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                         |  |
| Anthony Ward, Crisfield, Md.   |         |                              |  |  |   |   | DATE JUN 24 1968  |  | Charles Judge                                      |  |



3392



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 16 (4)  
30M REV 1/68

09209

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09214

|   |  |   |  |  |   |   |   |  |  |
|---|--|---|--|--|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>JOHN JOSEPH SCHELSHORN</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>3</b> Year <b>1968</b>               |  |   | 2b. HOUR<br><b>7 A M</b>  |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>May 6, 1892</b>   |   | 6. AGE (In years last birthday)<br><b>76</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>WICOMICO</b> Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Poultry man</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Wicomico</b>   |  | 13c. CITY OR TOWN <b>Salisbury</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>     |   | 13e. STREET AND NUMBER<br><b>Rt. 4,</b>                              |  |
| 14. FATHER'S NAME First <b>Karl</b> Middle <b>Schelshorn</b> Last <b>Adam</b>   |  |   | 15. MOTHER'S MAIDEN NAME First <b>Adelaide</b> Middle <b>Adam</b> Last <b>Adam</b> |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>War I</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-34-3957</b>  |  | 17. INFORMANT (Sister) <b>Rt. 4, Address Schumaker Road</b><br><b>Miss Agnes C. Schelshorn, Salisbury, Maryland</b>                                      |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary histoplasmosis</b><br><b>5319</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary emboli</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Gastric ulcer</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b><br><b>2 weeks</b><br><b>Acute</b> |  |   |  |  |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>5420</b>   |  |   |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>5-28-68</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Histoplasmosis</b>   |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                               |   |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-22</b> , 19 <b>68</b> , to <b>6-3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6-3</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Dr. E. Kent Carney</b>   |  |   |  |  | 22c. DATE SIGNED<br><b>June 4 / 1968</b>  |   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. E. Kent Carney</b>   |  |   |  |  | 22e. ADDRESS<br><b>Medical Center, Salisbury, Maryland</b>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>June 5, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parsons Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Wicomico, Maryland</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>JUN 6 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                           |  |  |

MEDICAL CERTIFICATION

1122

1122

1122

1122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 09210   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 09215  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>William K Scott  |  |  |  |  |  |  |  |  |  | Month Day Year<br>6 30 68   |  |  |  |  |  |  |  |  |  | 6 20 AM  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male  |  |  |  |  |  |  |  |  |  | 4. RACE<br>White  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>2-4-84   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)<br>84 YRS.  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>BERLIN   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>Wicomico - Salisbury Md.                                    |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Wicomico Nursing Home - Booth St.   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>RETIRED FARMER  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U. S. A.                                     |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE<br>MARYLAND   |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>WORCESTER  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>BERLIN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>William H. Scott   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Sophia Ellen West   |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br>No   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-72-0764   |  |  |  |  |  |  |  |  |  |
| 17. INFORMANT<br>Mrs. LENA WHITTINGTON  |  |  |  |  |  |  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 428 X Congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Complete A-V block<br>DUE TO, OR AS A CONSEQUENCE OF (c) Degenerative heart disease<br>4330<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>uremia - prostatic hypertrophy - anemia |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 mo. with yrs   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/28, 1968, to 6/30, 1968, that (I) (we) last saw the deceased alive on 6/28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br>[Signature]   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>6/30/68  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>[Signature]   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |  |  |  | 22f. DEGREE<br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>7/2/68   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreen  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION (City or Town) (County) (State)<br>Berlin Worcester Md.   |  |  |  |  |  |  |  |  |  | 23e. REC'D BY REGISTRAR<br>JUL - 5 1968   |  |  |  |  |  |  |  |  |  | 23f. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Anne A. Burbage Berlin Md.  |  |  |  |  |  |  |  |  |  | 24b. ADDRESS  |  |  |  |  |  |  |  |  |  | 24c. SIGNATURE   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

01525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

09211

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09216

|   |  |                              |  |  |          |   |  |  |  |                        |  |
|---|--|------------------------------|--|--|----------|---|--|--|--|------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |                              | First  | Middle   | Last     | 2a. DATE OF DEATH   |  |  | 2b. HOUR   |                        |  |
| Twin Girl # 1   |  |                              |  |  | SHOCKLEY | JUNE 8 1968   |  |  | 3:25 PM  |                        |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |          | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.       |  |
| FEMALE  |  | negro                        |  | June - 7, 1968   |          | YRS.  |  | MONTHS   |  | DAYS                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. COUNTY OF DEATH  |  |  |  |                        |  |
| Salisbury   |  | U.S.A                        |  |  |          | Wicomico Md.  |  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                        |  |
| Salisbury   |  |                              | Peninsula General Hospital   |  |          |   |  |  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |                              | 13b. COUNTY  |  |          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| Maryland  |  |                              | Worcester  |  |          | Ocean City  |  | YES  |  | Rt #1 Box 357          |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |  |          |   |  |  |  |                        |  |
| Charles F. Shockley   |  |                              | Rose Jackson   |  |          |   |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)  |  |                              | 16b. SOCIAL SECURITY NO.   |  |          | 17. INFORMANT   |  |  | Address  |                        |  |
|   |  |                              |  |  |          | Charles Shockley  |  |  | Box 357 Ocean City, Md.  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |          |   |  |  |  |                        |  |
| PART 1. DEATH WAS CAUSED BY:  |  |                              |  |  |          |   |  |  |  |                        |  |
| IMMEDIATE CAUSE (a) Immaturity (750gms) 777 x   |  |                              |  |  |          |   |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |          |   |  |  |  |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                              |  |  |          |   |  |  |  |                        |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |          |   |  |  |  |                        |  |
| (c)   |  |                              |  |  |          |   |  |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                              |  |  |          |   |  |  |  |                        |  |
| 776 x   |  |                              |  |  |          |   |  |  |  |                        |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |  |
|   |  |                              |  |  |          |   |  |  |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY  |  |          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |  |                        |  |
|   |  |                              | HOUR A.M. Month Day Year P.M. 19   |  |          |   |  |  |  |                        |  |
| 21d. INJURY OCCURRED  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |          | 21f. LOCATION   |  |  | City or Town County State  |                        |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              |  |  |          | Street or R.F.D. No.  |  |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/7 1968, to 6/8 1968, that (I) (we) just saw the deceased alive on 6/8 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |          |   |  |  |  |                        |  |
| 22b. SIGNATURE  |  |                              |  |  |          | 22c. DATE SIGNED  |  |  |  |                        |  |
| Alfred C. Kells MD  |  |                              |  |  |          | 6/8/68  |  |  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              |  |  |          | 22e. ADDRESS  |  |  |  |                        |  |
|   |  |                              |  |  |          | Medical Center Salisbury, Md.   |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |  |          | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION (City or town) (County) (State)                        |                        |  |
| Burial  |  |                              | 6-12-68  |  |          | Sarah Dukes   |  |  | Bishop Wicomico, Md.   |                        |  |
| 24. FUNERAL DIRECTOR  |  |                              |  |  |          | 25a. REC'D BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE   |                        |  |
| Lorella B. Jolley   |  |                              |  |  |          | JUN 18 1968   |  |  | Charles Judge  |                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |                                     |  |  |  |  |
|---|--|---|--|---|-------------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |                                     |  |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |                                     |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Juven Girl #2</i> First Middle Last  |  |   |  |   | 2a. DATE OF DEATH<br>Month Day Year |  |  | 2b. HOUR<br>M                                  |  |
| 3. SEX<br><i>FEMALE</i>   |  | 4. RACE<br><i>negro</i>   |  | 5. DATE OF BIRTH<br><i>6-7-68</i>   |                                     | 6. AGE (In years last birthday)<br>YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                 |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>SALISBURY</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH<br><i>Wicomico</i> Wicomico Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Salisbury</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Peninsula General Hospital</i> |  |   |                                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR INDUSTRY              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Worcester</i>   |  | 13c. CITY OR TOWN<br><i>Ocean City</i>  |                                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>Rt #1 Box 357</i> |  |
| 14. FATHER'S NAME<br>First Middle Last<br><i>Charles F. Shookley</i>  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><i>Rose Jackson</i>  |  |   |                                     |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |  | 17. INFORMANT<br><i>Charles Shookley</i>  |                                     | Address <i>W. Ocean City Rt #1 Box 357</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>777 X</i><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>776 X</i> <i>Juven birth</i> |  |   |  |   |                                     |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No.  |                                     | City or Town   |  | County State                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/7</i> , 19 <i>68</i> , to <i>6/8</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6/8</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                                     |  |  |  |  |
| 22b. SIGNATURE<br><i>D. S. Underwood</i>  |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |                                     | 22c. DATE SIGNED<br><i>6/8/68</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |   |  | 22e. ADDRESS  |                                     |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><i>6-12-68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>SARAH DUKES</i>  |                                     | 23d. LOCATION (City or Town) (County) (State)<br><i>Bishop WORE. MD.</i>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Loretta B. Jolley</i>  |  | ADDRESS<br><i>Jessy B. Rt 2 Salisbury, Md.</i>  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>JUN 18 1968</i>  |                                     | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |  |

3812014

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-6. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                              |  |  |   |  |  |                                   |  |
|--|---------|------------------------------|--|--|---|--|--|-----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                              |  |  |   |  |  |                                   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First  | Middle   | Last  | 2a. DATE KNOWN OF DEATH  |  |                                   | 2b. HOUR                                     |
| MONROE   |         |                              |  | SHEILY   | SMACK   | ESTIMATED <input checked="" type="checkbox"/> Month Day Year June 21 1968                    |  |                                   | M  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             |  | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |                                   | 2c. DATE PRONOUNCED DEAD                     |
| Male   | White   | 25 Apr. 1905                 |  | 63 YRS.  | 1 26  |  |  |                                   | Month Day Year June 21 1968                  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                   |  |
| Maryland   |         | U S A                        |  |  |   | WICOMICO Md.   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Salisbury  |         |                              | D.O.A. Pen. Gen. Hospital  |  |   | Poultry Grower   |  | Chicken                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE  |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER   |                                   |  |
| Maryland   |         |                              | Wicomico   |  | Delmar  | R.D.#3 Melson  |  |                                   |  |
| 14. FATHER'S NAME  |         |                              | First  | Middle   | Last  | 15. MOTHER'S MAIDEN NAME   |  |                                   | First Middle Last                            |
| PETER  |         |                              |  |  | SMACK   | SALLY  |  |                                   | (UNK)  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT (Name and address)   |  |                                   |  |
| No   |         |                              |  |  |   | Mrs. Florida H. Smack (Wife) R.D.#3 Melson Delmar, Maryland                                  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |         |                              |  |  |   |  |  |                                   | minutes                                      |
| IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>  |         |                              |  |  |   |  |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |  |   |  |  |                                   |  |
| (b) <u>Arteriosclerotic cardio-vascular disease</u> years  |         |                              |  |  |   |  |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |  |   |  |  |                                   |  |
| (c)  |         |                              |  |  |   |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |  |   |  |  |                                   |  |
| 4221   |         |                              |  |  |   |  |  |                                   |  |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>  |         |                              | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |                                   |  |
| N/A  |         |                              | N/A 19   |  | N/A   |  |  |                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   | County                            | State  |
| N/A  |         |                              | N/A  |  | N/A   |  |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                              |  |  |   |  |  |                                   |  |
| ACTUAL SIGNATURE   |         |                              | M.D.   |  |   | 22b. DATE SIGNED   |  |                                   |  |
| EXAMINER'S NAME (Type)   |         |                              | Dr. Earl L. Royer  |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |  |                                   | June 21 /1968                                |
| 409 Camden Ave. Salisbury, Md.   |         |                              |  |  |   | ADDRESS (Street, city, town, or county)  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE                    |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |  |
| Burial   |         | 23 June 1968                 |  | St. Johns Cemetery   |   | Powellville, Maryland  |  |                                   |  |
| 24. FUNERAL DIRECTOR   |         |                              |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE        |  |
| HOLLOWAY & COMPANY   |         |                              |  | SALISBURY, MARYLAND  |   | DATE JUN 24 1968   |  | Charles Judge                     |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 451514  
30M REV. 7-68

|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 09214  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 09219  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Grace Smith  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>June 7 1968   |  |  |  |  |  |  |  |  |  | 2b. HOUR<br>M  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female   |  |  |  |  | 4. RACE<br>White   |  |  |  |  | 5. DATE OF BIRTH<br>Mar. 9, 1888  |  |  |  |  | 6. AGE (In years last birthday)<br>80 YRS.   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Pa.   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Wicomico Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula General Hospital |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>housewife  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Va.   |  |  |  |  | 13b. COUNTY<br>none  |  |  |  |  | 13c. CITY OR TOWN<br>Alex.  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>209 E. Delray Ave.               |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>George William Cunningham   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Annie Sherman  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)<br>no   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT Address<br>Mrs. Hazel Vouros 209 E. Delray Ave.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>410.9<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary Atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>420.1 |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 days<br>5 days<br>Not Known   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/2/68, to 6/7/68, that (I) (we) last saw the deceased alive on 6/7/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Burton   |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Burton   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  | 23b. DATE<br>6-10-68   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wash. Nat'l Cemetery  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Md.                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Everly-Wheatley Funeral Home, Alex. Va.  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE JUN 11 1968   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Jones  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 09213 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09220   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| Item #1, taken from Application CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>WILLIAM F. T. SMULLEN   |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>JUNE 25 1968   |   |  | 2b. HOUR<br>8:40 P M                                    |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>June 30 1902   |  | 6. AGE (In years last birthday)<br>65 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Wicomico Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br>Peninsula General Hospital |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  |  | 13b. COUNTY<br>Worcester   |  | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET AND NUMBER<br>RFD. Snowhill                              |   |  |
| 14. FATHER'S NAME First Middle Last<br>James Smullen  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Priscilla Dykes  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address<br>Austin Smullen RFD Snowhill, Md.  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>0381</u> Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF <u>3rd Acute Bacterial Endocarditis</u> 10 days.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF <u>Staphylococcus Septicemia</u> 15 days.<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>0531</u> Diabetes. |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-21-68</u> , 19 <u>68</u> , to <u>6-25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6-25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Joseph C. Fitzgerald M.D.   |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>6-29-68  |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  | 22e. ADDRESS   |   |  |   |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br>6/28/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Olivet   |  | 23d. LOCATION (City or Town) (County) (State)<br>Somerset Md.                           |  |   |  |
| 24. FUNERAL DIRECTOR<br>James Lennin Prince   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>JUL - 3 1968  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |   |  |

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White

M2

K2

Peninsula General Hospital

M3

Wentworth

James

Donnell

Pringle

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1928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VP 475 (4)  
30M REV. 1/68

|  |  |  |                                      |  |  |  |  |
|--|--|--|--------------------------------------|--|--|--|--|
| 09216  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                    |                                      |  |  | 09221  |  |
| CERTIFICATE OF DEATH   |  |  |                                      |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>MONTGOMERY W. STAGG</b>  |  |  | 2a. DATE OF DEATH <b>JUNE 1 1968</b> |  |  | 2b. HOUR <b>9 30 PM</b>  |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b>   |                                      | 5. DATE OF BIRTH <b>MAY 18, 1905</b>   |  | 6. AGE (in years last birthday) <b>63</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>NORFOLK County</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Wicomico</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH <b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b> |                                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  | 13b. COUNTY <b>NORFOLK</b>   |                                      | 13c. CITY OR TOWN <b>Snow Hill</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER <b>Rt # 1</b>   |  | 14. FATHER'S NAME First Middle Last <b>HEROY P. STAGG</b>  |                                      | 15. MOTHER'S MAIDEN NAME First Middle Last <b>LOLA HAWCOCK</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>   |  | 16b. SOCIAL SECURITY NO. <b>214-10-6043</b>  |                                      | 17. INFORMANT <b>MRS. MARY CROPPER</b>   |  | 17b. ADDRESS <b>213 W. Market St Snow Hill, MD.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Failure</b><br><b>491X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic Bronchitis and</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Pulm. Emphysema</b><br><b>years.</b> |  |  |                                      |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>5020</b>  |  |  |                                      |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |                                      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |                                      | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-28</b> , 19 <b>68</b> , to <b>6-1</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6-1</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |                                      |  |  |  |  |
| 22b. SIGNATURE <b>Joseph C. Fitzgerald M.D.</b>  |  |  |                                      | 22c. DATE SIGNED <b>1 JUNE 68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>JOSEPH C. FITZGERALD MD.</b>   |  |  |                                      | 22e. ADDRESS <b>Medical Center Wico. County</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE <b>6/4/1968</b>  |                                      | 23c. NAME OF CEMETERY OR CREMATORY <b>BATES METHODIST</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Snow Hill MD.</b>                           |  |
| 24. FUNERAL DIRECTOR <b>Guadalupe Sandoz</b>   |  |  |                                      | 24a. REC'D BY REGISTRAR <b>Charles Judge</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |
| ADDRESS <b>Snow Hill, MD.</b>  |  |  |                                      | DATE <b>JUN 5 1968</b>   |  |  |  |

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2019-2020

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 175  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |                                       |   |   |  |   |                                |   |
|--|--|---|---------------------------------------|---|---|--|---|--------------------------------|---|
| CERTIFICATE OF DEATH   |  |   |                                       |   |   |  |   |                                |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First                                 | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year  |   |                                | 2b. HOUR  |
| LEE  |  |   |                                       |   | SUTTON  | June 3 1968  |   |                                | 6:20P M   |
| 3. SEX   |  | 4. RACE   |                                       | 5. DATE OF BIRTH  |   | 6. AGE (In years<br>last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS |   |
| Male   |  | Colored   |                                       | 8/23/1901   |   | 66 YRS.  |   |                                |   |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   | Md.                            |   |
| North Carolina.  |  | U S A   |                                       |   |   | WICOMICO   |   |                                |   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                                       | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |   |                                |   |
| Salisbury  |  | Deer's Head State Hospital  |                                       | None  |   | None   |   |                                |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  | 13b. COUNTY   |                                       | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER         |   |
| Maryland   |  | Somerset  |                                       | Princess Anne   |   |  |   | 328 Hampton Avenue             |   |
| 14. FATHER'S NAME  |  |   | First                                 | Middle  | Last  | 15. MOTHER'S MAIDEN NAME   |   |                                | First Middle Last   |
| <del>XXXXXXXXXXXX</del>  |  |   | Willie Sutton                         |   |   | Jenny Mullen   |   |                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |   | (If yes give war or dates of service) |   |   | 16b. SOCIAL SECURITY NO.   |   |                                | 17. INFORMANT<br>Address  |
|  |  |   |                                       |   |   |  |   |                                | Ernest Sutton, Newark, N.J.   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Recurrent cerebral vascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.   |  |   |                                       |   |   |  |   |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>8 hours<br>Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>443X</u>   |  |   |                                       |   |   |  |   |                                |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |                                |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                                       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |                                |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 30</u> , 19 <u>53</u> , to <u>June 3</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <u>June 3</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |                                       |   |   |  |   |                                |   |
| 22b. SIGNATURE<br><u>C. H. Winnacott, M. D.</u>  |  |   |                                       |   | ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>6/4/68</u>                                       |                                |   |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |   |                                       |   | 22e. ADDRESS  |  |   |                                |   |
| C. H. Winnacott, M. D.   |  |   |                                       |   | Deer's Head State Hospital, Salisbury,  |  |   |                                |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |                                       | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |   |                                |   |
| Burial   |  | 6/6/68  |                                       | Mt Carmal   |   | Princess Anne, Md  |   |                                |   |
| 24. FUNERAL DIRECTOR<br>ADDRESS  |  |   |                                       |   | 25a. REC'D BY REGISTRAR<br>DATE   |  | 25b. REGISTRAR'S SIGNATURE  |                                |   |
| William H. James Jr, Princess Anne, Md   |  |   |                                       |   | JUN 11 1968   |  | <u>Charles Judge</u>  |                                |   |

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13.4  
30M REV. 1-68

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
- CERTIFICATE OF DEATH

09223

|   |  |   |  |   |   |  |   |   |                                      |  |  |
|---|--|---|--|---|---|--|---|---|--------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First<br>HENRY   | Middle<br>E.  | Last<br>SWEET                           | 2a. DATE OF DEATH<br>Month<br>June<br>Day<br>9<br>Year<br>1968   |   |   | 2b. HOUR<br>6:30 P.M.                |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>February 10, 1896   |   | 6. AGE (In years<br>last birthday)<br>72 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                                       |                                      | IF UNDER 24 HRS.<br>HOURS<br>MIN.                    |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Rhode Island  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>WICOMICO Md.   |   |   |                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>R.D.#1, Sharps Point |  |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retired lawyer |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Wicomico   |  | 13c. CITY OR TOWN<br>Salisbury  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                         |   | 13e. STREET AND NUMBER<br>R.D.#1, Sharps Point                          |                                      |  |  |
| 14. FATHER'S NAME<br>First<br>Henry<br>Middle<br>E.<br>Last<br>Sweet, Sr.   |  |   | 15. MOTHER'S MAIDEN NAME<br>First<br>Julia<br>Middle<br>Eldredge<br>Last |   |   |  |   |   |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>Yes  |  |   | (If yes give war or dates of service)<br>War I                           |   | 16b. SOCIAL SECURITY NO.<br>216-46-3034 |  | 17. INFORMANT (Administrator)<br>Mrs. Eleanor A. Crawford, Glen Burnie, Md. |   |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>coronary thrombosis</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <u>arteriosclerotic heart disease</u> yrs<br>(c) <u>generalized arteriosclerosis</u> yrs |  |   |  |   |   |  |   |   |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>— |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4201</u> <u>Diabetes Mellitus</u>  |  |   |  |   |   |  |   |   |                                      |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |   |                                      |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |   | County  |                                      | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>66</u> , to <u>6-9</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>June 6</u> , 19 <u>66</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |   |                                      |  |  |
| 22b. SIGNATURE<br><u>John T. Bulkeley</u>   |  |   |  |   |   | 22c. DATE SIGNED<br>June 10 / 1968   |   | 22d. PHYSICIAN'S<br>NAME (Type) Dr. John T. Bulkeley                    |                                      |  |  |
| 22e. ADDRESS<br>Pine Bluff Road, Salisbury, Maryland  |  |   |  |   |   |  |   |   |                                      |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>June 13, 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wicomico Memorial Park  |   | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Wicomico, Maryland                               |   |   |                                      |  |  |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |  |   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE JUN 13 1968  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                      |                                      |  |  |

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/01 BY 60322 UCBAW/STP

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |         |   |                                      |  |   |  |     |   |  |
|---|---------|---|--------------------------------------|--|---|--|-----|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |   |                                      |  |   |  |     |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |   |                                      |  |   |  |     |   |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |   | First Middle Lost                    |  |   | 2a. DATE KNOWN OF DEATH  |     |   | 2b. HOUR                                     |
| ADDIE BROWN TALBOTT   |         |   |                                      |  |   | <input checked="" type="checkbox"/> Month Day Year<br><input type="checkbox"/> ESTIMATED <input type="checkbox"/> June 11 1968 |     |   | 10:30 AM                                     |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (In years last birthday)      | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS  |     | 2c. DATE PRONOUNCED DEAD  |  |
| Female  | White   | December 12, 1876   | 91 YRS.                              | MONTHS   | DAYS  | HOURS  | MIN | Month Day Year  | 2d. HOUR                                     |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |     |   |  |
| West Virginia   |         | USA   |                                      |  |   | WICOMICO   |     |   | Md.  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street, address) |                                      |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |     | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Salisbury   |         | R.D.#3, Zion Road   |                                      |  | House work  |  |     | none  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |   |                                      | 13b. COUNTY  |   | 13c. CITY OR TOWN  |     | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |         |   |                                      | Wicomico   |   | Salisbury  |     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME   |         |   |                                      | 15. MOTHER'S MAIDEN NAME   |   | 13e. STREET AND NUMBER   |     |   |  |
| First Middle Lost   |         |   |                                      | First Middle Lost  |   | R.D.#3, Zion Road  |     |   |  |
| Lewis Greynolds   |         |   |                                      | Martha Jones   |   |  |     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |   | 16b. SOCIAL SECURITY NO.             |  | 17. INFORMANT (Son-in-law)  |  |     | ADDRESS   |  |
| No  |         |   | 233-80-4359                          |  | J1 Mr. Robert Samworth, Salisbury, Maryland   |  |     | R.D.#3, Zion Road   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |   |                                      |  |   |  |     |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |         |   |                                      |  |   |  |     |   |  |
| IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>   |         |   |                                      |  |   |  |     |   | sudden                                       |
| DUE TO, OR AS A CONSEQUENCE OF  |         |   |                                      |  |   |  |     |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |         |   |                                      |  |   |  |     |   |  |
| (b) <u>Arteriosclerotic cardio-vascular disease</u> years   |         |   |                                      |  |   |  |     |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |   |                                      |  |   |  |     |   |  |
| (c)   |         |   |                                      |  |   |  |     |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |   |                                      |  |   |  |     |   |  |
| 4201 Gangrene of right foot.  |         |   |                                      |  |   |  |     |   |  |
| 19a. DATE OF OPERATION  |         |   |                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |     | 2D. AUTOPSY?  |  |
|   |         |   |                                      |  |   |  |     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>   |         |   | 21b. TIME OF INJURY Month, Day, Year |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |     |   |  |
| CAUSE OF DEATH  |         |   | HOUR A.M. P.M.                       |  | 19  |  |     |   |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |                                      | 21f. LOCATION Street or R.F.D. No.   |   | City or Town   |     | County  | State  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |   |                                      |  |   |  |     |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |                                      |  |   |  |     |   |  |
| ACTUAL SIGNATURE  |         |   |                                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  |     | 22b. DATE SIGNED  |  |
| EXAMINER'S NAME (Type)  |         |   |                                      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  |     | June 11 / 1968  |  |
| Earl L. Royer, M.D.   |         |   |                                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |     |   |  |
| 409 Camden Ave., Salisbury, Maryland  |         |   |                                      | ADDRESS (Street, city, town, or county)  |   |  |     |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE   |                                      | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |     |   |  |
| Burial  |         | June 15, 1968   |                                      | Green Lawn Cemetery  |   | Elkins, Randolph, W. Virginia  |     |   |  |
| 24. FUNERAL DIRECTOR  |         |   |                                      | ADDRESS  |   | 25a. REC'D BY REGISTRAR  |     | 25b. REGISTRAR'S SIGNATURE  |  |
| HOLLOWAY & COMPANY, SALISBURY, MARYLAND   |         |   |                                      |  |   | DATE JUN 17 1968   |     | Charles Judge   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |  |  |   |  |                  |
|--|--|--|--|---|---|--|--|---|--|------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |  |  |   |  |                  |
| CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |   |  |                  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH  |  |   | 2b. HOUR   |                  |
| JAMES AUGUSTINE TAYLOR   |  |  |  |   |   | Month  | Day  | Year  | 8 P. M.  |                  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |                  |
| Male   |  | White  |  | Aug. 9, 1879  |   | 88 YRS.  |  |   |  |                  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |   |  |                  |
| Maryland   |  | U.S.A.   |  |   |   | Wicomico Md.   |  |   |  |                  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                  |
| Salisbury  |  |  | Springhill Sanatorium  |   |   | Police Dept. Supt. Ret.  |  |   | Law Enforce  |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER  |  |                  |
| Maryland   |  |  | Wicomico   |   | Salisbury   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |  | 227 N. Clairmont  |  |                  |
| 14. FATHER'S NAME  |  |  | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME   |  |   | First Middle Last  |                  |
| Sewell   |  |  | T.   |   | Taylor  | Sarah  |  |   | Devereau   |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  |  |   |  |                  |
| No.  |  |  | 212-16-7493-A  |   | Mrs. W. Eugene Bounds, See Sec 13                                   |  |  |   |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden.</u> |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)<br><u>4201</u>   |  |  |  |   |   |  |  |   |  |                  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |                  |
|  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |   |  |                  |
|  |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |   |  |  |   |  |                  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |   | Street or R.F.D. No.   |  | City or Town  | County State   |                  |
| While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |   |   |  |  |   |  |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>64</u> , to <u>June 12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June 12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                   |  |  |  |   |   |  |  |   |  |                  |
| 22b. SIGNATURE   |  |  |  |   | DEGREE  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED |
| <u>Robert T. Adkins</u>  |  |  |  |   |   |  |  |   |  | 6-13-1968        |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |   | 22e. ADDRESS  |  |  |   |  |                  |
| Dr. Robert T. Adkins   |  |  |  |   | Fruitland, Maryland   |  |  |   |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)   |  | (County)  | (State)  |                  |
| Burial   |  | 6-14-1968  |  | Wicomico Memorial Park  |   | Salisbury, Maryland  |  |   |  |                  |
| 24. FUNERAL DIRECTOR   |  |  |  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |   |  |                  |
| Hill Funeral Home Salisbury, Maryland  |  |  |  |   | DATE JUN 17 1968  |  | <u>Charles J. Jones</u>  |   |  |                  |

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1. The first group of respondents (Group 1) consisted of 100 individuals who were randomly selected from the population of 1,000 individuals. This group was used to estimate the overall population mean and standard deviation.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |              |   |  |  |  |  |  |   |  |
|---|--------------|---|--|--|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |              |   |  |  |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or Print)   |              | First<br>GARDNER  |  | Middle<br>LEE  |  | Last<br>THOMAS   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 6-13-68 19 5:45 AM |  |
| 3. SEX<br>M   | 4. RACE<br>W | 5. DATE OF BIRTH<br>8-10-1883   |  | 6. AGE (In years last birthday)<br>84 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Delaware   |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Wicomico   |  | 2c. DATE PRONOUNCED DEAD Month 6 Day 13 Year 1968 5:45 AM                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Peninsula General |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Pennsylvania Railroad Ticket                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Agent   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Del.  |              | 13b. COUNTY<br>Sussex   |  | 13c. CITY OR TOWN<br>Frankford   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>Clayton Ave.  |  |
| 14. FATHER'S NAME<br>Henry  |              | First Middle Last<br>Thomas   |  | 15. MOTHER'S MAIDEN NAME<br>Elizabeth  |  | First Middle Last<br>Thomas  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No  |              | (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br>716-01-6725  |  | 17. INFORMANT<br>Elizabeth Thomas  |  | ADDRESS<br>Frankford, Del.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Arteriosclerotic cardio-vascular disease</u> years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u> |              |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4201</u>  |              |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                      |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |  | County State  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                |              |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br><u>Earl L. Royer, M.D.</u>  |              | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |  | 22b. DATE SIGNED<br>June 13, 1968   |  |
| EXAMINER'S NAME (Type)<br>409 Camden Ave., Salisbury, Md.   |              | ADDRESS (Street, city, town, or county)   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |              | 23b. DATE<br>6/16/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dagsboro Memorial  |  | 23d. LOCATION (City or Town) (County) (State)<br>Dagsboro, Sussex Del.                       |  |   |  |
| 24. FUNERAL DIRECTOR<br>Watson, Gray & Nelson, Salisbury, Del.  |              | ADDRESS<br>Frankford  |  | 25a. REC'D BY REGISTRAR<br>DATE JUN 19 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |   |  |

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MEDICAL EXAMINE, TESTIMONY OF DEATH

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# FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
|--|--|--|--|--|------------------------------------|--|---------------------------------|---|--|--|-----------------------------------|-------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |  | First  |  | Middle                             |  | Last                            |   | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR                          |                   |  |
| RICHARD  |  |  | LEE  |  | TULL                               |  |                                 |   | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR                          |                   |  |
| 3. SEX   |  |  | 4. RACE  |  | 5. DATE OF BIRTH                   |  | 6. AGE (In years last birthday) |   | 7c. DATE PRONOUNCED DEAD   |  | 7d. HOUR                          |                   |  |
| Male   |  |  | White  |  | August 15, 1940                    |  | 27 YRS.                         |   | June 1 Day   |  | 1968                              |                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |   | 9. COUNTY OF DEATH   |  |                                   | Md.               |  |
| Delaware   |  |  | USA  |  |                                    |  |                                 |   | WICOMICO   |  |                                   |                   |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    |  |                                 |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  | 12b. KIND OF BUSINESS OR INDUSTRY |                   |  |
| Salisbury  |  |  | Peninsula General Hospital   |  |                                    |  |                                 |   | Laborer  |  | Acoustical Tile                   |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN  |                                 |   | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER            |                   |  |
| Maryland   |  |  | Wicomico   |  |                                    | Quantico   |                                 |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  | R.D.#1, Sandy Hill Road           |                   |  |
| 14. FATHER'S NAME  |  |  | First  |  | Middle                             |  | Last                            |   | 15. MOTHER'S MAIDEN NAME   |  |                                   | First Middle Last |  |
| Norris   |  |  | W.   |  | Tull                               |  |                                 |   | Violet   |  |                                   | Roach             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT (Wife)   |                                 |   | R.D.#1 ADDRESS   |  |                                   | Sandy Hill Road   |  |
| No   |  |  | 214-36-6088  |  |                                    | Mrs. Jo Ann Tull, Quantico, Maryland   |                                 |   |  |  |                                   |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                                    |  |                                 |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                   |                   |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |                                    |  |                                 |   |  | sudden                                       |                                   |                   |  |
| IMMEDIATE CAUSE (a) <u>Crushed chest and abdomen</u>   |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| (b) <u>816.0</u>   |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| (c)  |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| <u>823.4</u>   |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |                                    |  |                                 |   | 20. AUTOPSY?   |  |                                   |                   |  |
|  |  |  |  |  |                                    |  |                                 |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |                                   |                   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY Month, Day, Year   |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                 |   |  |  |                                   |                   |  |
|  |  |  | 7:50 P.M. 6-1-1968   |  |                                    | Driver of auto that ran off road and overturned.   |                                 |   |  |  |                                   |                   |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                    | 21f. LOCATION Street or R.F.D. No.   |                                 |   | City or Town County State  |  |                                   |                   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  | road   |  |                                    | Royal Oak Rd., Royal Oak, Wicomico, Md.  |                                 |   |  |  |                                   |                   |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |  |                                    |  |                                 |   |  |  |                                   |                   |  |
| ACTUAL SIGNATURE   |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |  |                                    |  |                                 |   | 22b. DATE SIGNED   |  |                                   |                   |  |
| EXAMINER'S NAME (Type)   |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                          |  |                                    |  |                                 |   | June 3 / 1968  |  |                                   |                   |  |
| 409 Camden Ave., Salisbury, Md.  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |  |                                    |  |                                 |   | ADDRESS (Street, city, town, or county)  |  |                                   |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |                                 | 23d. LOCATION (City or Town) (County) (State) |  |  |                                   |                   |  |
| Burial   |  |  | June 5, 1968   |  | Parsons Cemetery                   |  |                                 | Salisbury, Wicomico, Maryland                 |  |  |                                   |                   |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  |                                    | 25a. REC'D BY REGISTRAR  |                                 | 25b. REGISTRAR'S SIGNATURE                    |  |  |                                   |                   |  |
| HOLLOWAY & COMPANY, SALISBURY, MARYLAND  |  |  |  |  |                                    | DATE JUN 6 1968  |                                 | J. Charles Jones                              |  |  |                                   |                   |  |

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JUN 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09223

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09228

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <u>Uelma Sterling Victory</u>   |  |   |  | 2a. DATE OF DEATH<br>Month <u>June</u> Day <u>26</u> Year <u>1968</u>   |  |   |  | 2b. HOUR<br><u>7:10</u> A M   |  |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>Negro</u>   |  | 5. DATE OF BIRTH<br><u>3/17/1905</u>  |  | 6. AGE (In years last birthday)<br><u>63</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____<br>IF UNDER 24 HRS.<br>HOURS _____ MIN _____ |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Crisfield</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>Wicomico</u> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Salisbury</u>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Peninsula General Hospital</u> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>LABORER</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>SEAFOOD</u>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>Md</u>  |  | 13b. COUNTY<br><u>SOMERSET</u>  |  | 13c. CITY OR TOWN<br><u>Crisfield</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><u>Rural</u>  |  |
| 14. FATHER'S NAME<br>First <u>William</u> Middle _____ Last <u>WATERS</u>   |  | 15. MOTHER'S MAIDEN NAME<br>First <u>SARAH H.</u> Middle _____ Last <u>DIX</u>                                    |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><u>218-03-7291</u>  |  | 17. INFORMANT<br><u>Reginald Victory-Crisfield Md.</u> Address _____  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>403X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Nephrosclerosis</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____    |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Years.</u>                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>446X Hypertension</u>  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year <u>19</u><br>P.M. _____                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-20</u> , 19 <u>68</u> , to <u>6-26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>26 June</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Joseph C. Fitzgerald</u> M.D. DEGREE _____   |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><u>6-29-68</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |   |  | 22e. ADDRESS  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><u>7/1/68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Asbury</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Crisfield</u> <u>Md</u>                     |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Anthony E. Ward</u>  |  |   |  | ADDRESS<br><u>Crisfield Md.</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL - 2 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                      |  |

MEDICAL CERTIFICATION



collected



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |  |  |  |   |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>ELWOOD B WALLS</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>2</b> Year <b>1968</b> |  |  | 2b. HOUR<br><b>9:10</b> AM   |  |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>9-23-1907</b>   |  | 6. AGE (In years last birthday)<br><b>60</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>        |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Del.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Peninsula General Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>FARMER</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FARMING</b>   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Del.</b>  |  | 13b. COUNTY<br><b>Sussex</b>  |  | 13c. CITY OR TOWN<br><b>MILTON</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>RD</b>                   |  |  |  |
| 14. FATHER'S NAME<br>First <b>FRANK</b> Middle <b>B</b> Last <b>WALLS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>SUSAN</b> Middle <b>E</b> Last <b>PETTYJOHN</b>                              |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>221-10-8299</b>   |  | 17. INFORMANT<br>Address <b>LIDA F. MOORE - MILTON, Del</b>                                  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>185X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Adenocarcinoma of prostate with</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>Generalized metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 wk</b><br><b>24 mm.</b> |  |   |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>177X</b>   |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>177X</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 13, 1968</b> , to <b>June 2, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Raymond M. Yaw</b> MD  |  |   |  | 22c. DATE SIGNED<br><b>June 2, 1968</b>  |  |  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>RAYMOND M. YAW</b> |  |  |  |
| 22e. ADDRESS<br><b>MEDICAL CENTER, SALISBURY, MARYLAND</b>  |  |   |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>June 6-5-1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HENLOPEN PARK</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>MILTON - SUSSEX - DEL</b>                |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>William E. Schom Jr. Seaford, Del.</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 6 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |  |  |  |

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is followed by a detailed account of the work done in each of the various departments, and a summary of the results achieved.

2. The second part of the report deals with the financial statement of the year, and the progress of the work in the various departments. It is followed by a detailed account of the work done in each of the various departments, and a summary of the results achieved.

3. The third part of the report deals with the financial statement of the year, and the progress of the work in the various departments. It is followed by a detailed account of the work done in each of the various departments, and a summary of the results achieved.

4. The fourth part of the report deals with the financial statement of the year, and the progress of the work in the various departments. It is followed by a detailed account of the work done in each of the various departments, and a summary of the results achieved.

5. The fifth part of the report deals with the financial statement of the year, and the progress of the work in the various departments. It is followed by a detailed account of the work done in each of the various departments, and a summary of the results achieved.

6. The sixth part of the report deals with the financial statement of the year, and the progress of the work in the various departments. It is followed by a detailed account of the work done in each of the various departments, and a summary of the results achieved.

7. The seventh part of the report deals with the financial statement of the year, and the progress of the work in the various departments. It is followed by a detailed account of the work done in each of the various departments, and a summary of the results achieved.

8. The eighth part of the report deals with the financial statement of the year, and the progress of the work in the various departments. It is followed by a detailed account of the work done in each of the various departments, and a summary of the results achieved.

9. The ninth part of the report deals with the financial statement of the year, and the progress of the work in the various departments. It is followed by a detailed account of the work done in each of the various departments, and a summary of the results achieved.

10. The tenth part of the report deals with the financial statement of the year, and the progress of the work in the various departments. It is followed by a detailed account of the work done in each of the various departments, and a summary of the results achieved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |   |        |   |  |   |  |   |                          |  |       |
|--|--|---|--------|---|--|---|--|---|--------------------------|--|-------|
| 1. DECEASED-NAME<br>(Type or print) <b>Annie</b>   |  | First   | Middle | Last  | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>7</b> Year <b>1968</b>                 |   | 2b. HOUR <b>5:15</b> P <b>M</b>                                      |   |                          |  |       |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |        | 5. DATE OF BIRTH<br><b>Nov. 3, 1870</b>   |  | 6. AGE (In years last birthday)<br><b>97</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS                     | IF UNDER 24 HRS.<br>DAYS | HOURS  | MIN.  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PENN.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.   |  |   |                          |  |       |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Deer's Head State Hospital</b> |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  |   |                          |  |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>SOMERSET</b>  |        | 13c. CITY OR TOWN<br><b>CRISFIELD</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>203 MAIN ST.</b> |                          |  |       |
| 14. FATHER'S NAME First<br><b>SAMUEL</b>   |  | Middle<br><b>LANDIS</b>   |        | Last<br><b>MARY</b>   |  | 15. MOTHER'S MAIDEN NAME First<br><b>MARY</b>   |  | Middle<br><b>MAIST</b>                        |                          | Last   |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or <u>unknown</u> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>  |        | 17. INFORMANT<br><b>LESTER H. ZIMMERMAN</b>   |  | Address<br><b>MIFFLINTOWN, PA.</b>  |  |   |                          |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |        |   |  |   |  |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 Hr.</b><br><br><b>Years</b> |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4201</b><br><b>Fracture Left Femur</b>  |  |   |        |   |  |   |  |   |                          |  |       |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                          |  |       |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |        |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |  |   |                          |  |       |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |        |   | 21f. LOCATION Street or R.F.D. No.   |   | City or Town   |   | County                   |  | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/31/67</b> , 19____, to <b>6/7/68</b> , 19____, that (I) (we) last saw the deceased alive on <b>6/7/68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |        |   |  |   |  |   |                          |  |       |
| 22b. SIGNATURE<br><b>Charles Winnacott</b>   |  | DEGREE  |        | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED<br><b>6/8/68</b>   |  |   |                          |  |       |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Charles Winnacott, M. D.</b>  |  | 22e. ADDRESS<br><b>P. O. Box 2018, Salisbury, Md. - 21801</b>   |        |   |  |   |  |   |                          |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 23b. DATE<br><b>6/11/1968</b>   |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PRESBYTERIAN CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>MIFFLINTOWN JEWATA, PA.</b>                 |  |   |                          |  |       |
| 24. FUNERAL DIRECTOR<br><b>Hill Funeral Home</b>   |  | ADDRESS<br><b>SALISBURY MD.</b>   |        | 25a. REC'D BY REGISTRAR<br><b>JUN 12 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |                          |  |       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

09226

09231

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Joseph ALDEN WARRINGTON</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>1</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>11 39 PM</b>  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br><b>5-25-02</b>  |  | 6. AGE (In years last birthday)<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Delaware</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Wicomico</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, street address)<br><b>Peninsula General Hospital Salisbury</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Salesman</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BLDG. Supply</b>                                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Delaware</b>  |  | 13b. COUNTY<br><b>Sussex</b>  |  | 13c. CITY OR TOWN<br><b>Laurel</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>First <b>Joseph</b> Middle <b>C</b> Last <b>Warrington</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Jillie</b> Middle <b>Hastings</b> Last <b>Hastings</b>                             |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>222-098714</b>   |  | 17. INFORMANT<br>Address <b>Rebecca E. Warrington Laurel Del</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br><b>402X</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>443X</b><br>(b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension Heart Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 mins.</b><br><b>3 weeks.</b><br><b>Abd. known</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes mellitus, Nephropathy - Uremia</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/1/68</b> , to <b>6/1/68</b> , that (I) (we) last saw the deceased alive on <b>6/1/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |   |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>6-4-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Fellows Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Laurel Sussex Del</b>                    |  |
| 24. FUNERAL DIRECTOR<br><b>[Signature]</b>  |  |   |  | ADDRESS<br><b>[Signature]</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 7 1968</b>  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

00280

EXHIBIT OF DEATH

Wisconsin

00280



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>REESE</b>  |  |   | First Middle Last<br><b>C. WHITTINGTON</b>                           |   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>June 24 1968</b>                                   |  | 2b. HOUR<br><b>11:15A M</b>                             |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Colored</b>   |  | 5. DATE OF BIRTH<br><b>OCT. 8, 1892</b>   |  | 6. AGE (In years last birthday)<br><b>75</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>WICOMICO</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Deer's Head State Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Somerset</b>  |  | 13c. CITY OR TOWN<br><b>Marion Station</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Box 162 Marion Md.</b>     |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Philip H. Whittington</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Hanna Dennis</b> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-12-3572</b>                       |   | 17. INFORMANT<br>Address   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>485X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>491X</b><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 days</b> |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Recurrent cerebral thrombosis with right hemiplegia</b>  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that <del>XX</del> (this hospital) attended the deceased from <b>May 21</b> , 19 <b>68</b> , to <b>June 24</b> , 19 <b>68</b> , that <del>(s)</del> (we) last saw the deceased alive on <b>June 24</b> , 19 <b>68</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(X)</del> (we) (did) <del>(not)</del> view the body after death.               |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>C. H. Winnacott, M. D.</b>  |  |   |  |   | 22c. DATE SIGNED<br><b>6/24/68</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>C. H. Winnacott, M. D.</b>        |   |  |
| 22e. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Maryland</b>   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>6/27/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Marion</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Marion Md</b>                            |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Anthony E. Ward Crisfield MD.</b>   |  |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>JUL - 2, 1968</b>                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |   |  |

13325

CERTIFICATE OF DEATH

NAME: J. W. WILKINSON, JR. SEX: Male AGE: 72

DATE OF BIRTH: 12/15/1892 PLACE OF BIRTH: [illegible]

DECEASED AT: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: 1-1-1964

REGISTRATION NO.: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~the~~ <sup>the</sup> ~~pages~~ <sup>pages</sup> should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |   |  |  |                                |                      |                                |  |
|---|--|--|---|--|--|---|--|---|--|--|--------------------------------|----------------------|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |   |  |  |                                |                      |                                |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |   |  |  |                                |                      |                                |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>CORR   |  |  | Middle<br>MAE   |  | Last<br>WILLIAMS  |  | 2a. DATE OF DEATH<br>Month Day Year<br>June 17 68          |                                | 2b. HOUR A<br>9:50 M |                                |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH<br>11 May 1887   |  |   | 6. AGE (In years<br>last birthday)<br>81 YRS.                        |  | IF UNDER 1 YEAR<br>MONTHS DAYS |                      | IF UNDER 24 MRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Worcester   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br>WICOMICO                                       |  |                                |                      |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>R.D.#4 Ocean City Rd |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>House Work at Home  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>None                         |  |                                |                      |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Wicomico   |  |  | 13c. CITY OR TOWN<br>Salisbury  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  | 13e. STREET AND NUMBER<br>R.D.#4 Ocean City Rd.            |                                |                      |                                |  |
| 14. FATHER'S NAME<br>First Middle Last<br>JAMES HASTINGS  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>ADELINE  |  |  |   |  |   |  |  |                                |                      |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>4129  |  |  | 17. INFORMANT<br>Mr. Preston W. Williams (Son)<br>Rd. Salisbury, Maryland 21801   |  |   |  | Address  |                                |                      |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Degeneration<br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>last. (b) Generalized arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>gradual |                                |                      |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4221 Bronchial pneumonia rheumatoid arthritis  |  |  |   |  |  |   |  |   |  |  |                                |                      |                                |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?  |  |  |                                |                      |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. N/A 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)<br>N/A  |  |   |  |  |                                |                      |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)<br>N/A                  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>N/A   |  |   |  |  |                                |                      |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1966, to June 1968, that (I) (we) last<br>saw the deceased alive on June 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |   |  |  |                                |                      |                                |  |
| 22b. SIGNATURE<br>Robert T. Adkins  |  |  |   |  |  | DEGREE<br>ATTENDING<br>PHYS.  |  | <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>June 18 / 1968                         |                                |                      |                                |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Dr. Robert T. Adkins   |  |  |   |  |  | 22e. ADDRESS<br>Fruitland, Maryland   |  |   |  |  |                                |                      |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>June 19/68   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wicomico Memorial Park  |  |   | 23d. LOCATION (City or Town) (County) (State)<br>Salisbury, Maryland |  |                                |                      |                                |  |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY & COMPANY  |  |  |   |  |  | ADDRESS<br>SALISBURY, MARYLAND  |  | 25a. REC'D BY REGISTRAR<br>DATE JUN 20 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                |                                |                      |                                |  |

12345

12345

DATE OF BIRTH: 12/12/1945

NAME: J. D. SMITH

ADDRESS: 12345 MAIN ST, NEW YORK, NY 10001

TELEPHONE: (212) 123-4567

EMPLOYER: ABC COMPANY

EDUCATION: HIGH SCHOOL GRAD

RELIGION: PROTESTANT

POLITICAL AFFILIATION: REPUBLICAN

HOBBIES: GOLF, FISHING

TRAVEL HISTORY: EUROPE, ASIA

LANGUAGES: ENGLISH, SPANISH

SKILLS: DRIVING, SWIMMING

ACHIEVEMENTS: COLLEGE FOOTBALL

REFERENCES: JOHN DOE, JANE SMITH

COMMENTS: VERY NICE PERSON

REMARKS: NO OTHER INFO

ADDITIONAL INFO: NONE

DATE OF ENTRY: 12/12/1945

ENTRY NO: 12345

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VA 15-4  
30M REV. 12-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |         |  |  |   |   |   |  |                                |                                   |
|---|---------|--|--|---|---|---|--|--------------------------------|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |   |   |   |  |                                |                                   |
| CERTIFICATE OF DEATH  |         |  |  |   |   |   |  |                                |                                   |
| 1. DECEASED-NAME<br>(Type or print)   |         |  | First Middle Last  |   |   | 2a. DATE OF DEATH<br>Month Day Year   |  |                                | 2b. HOUR                          |
| JAMES B.  |         |  | WOODLEY  |   |   | JUNE 1, 1968  |  |                                | 1:45 PM                           |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH   |   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |                                   |
| male  | NEGRO   |  | 10/20/1896   |   |   | 71 YRS.   |  |                                |                                   |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                                |                                   |
| Md.   |         | U.S.   |  |   |   | Wicomico Md.  |  |                                |                                   |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY |
| Salisbury   |         |  | Peninsula General Hospital   |   |   | Railroad  |  |                                |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET AND NUMBER            |
| MARYLAND Wicomico   |         |  | BIVALLE  |   |   |   |  |                                |                                   |
| 14. FATHER'S NAME   |         |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |                                |                                   |
| First Middle Last   |         |  | First Middle Last  |   |   |   |  |                                |                                   |
| Henry Woodley   |         |  | Catherine Ruden  |   |   |   |  |                                |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If in service war or dates of service)  |         |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |   |  |                                |                                   |
| yes   |         |  | WW I 709-12-5768   |   | Maxion Woodley, Jester ville, Md.   |   |  |                                |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u><br>153.9 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malignant Carcinoid Rt. lung,</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic from small bowel.</u><br><u>Post-op. bowel resection</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 hrs -<br>5 days |         |  |  |   |   |   |  |                                |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>153.9   |         |  |  |   |   |   |  |                                |                                   |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                |                                   |
|   |         |  |  |   |   |   |  |                                |                                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |                                |                                   |
|   |         |  |  |   |   |   |  |                                |                                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |                                |                                   |
|   |         |  |  |   |   |   |  |                                |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |         |  |  |   |   |   |  |                                |                                   |
| 22b. SIGNATURE <u>W. J. Adler</u> M.D. - DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |         |  |  |   | 22c. DATE, SIGNED <u>6/1/68</u>   |   |  |                                |                                   |
| 22d. PHYSICIAN'S NAME (Type) <u>WILLIAM P. ADLER</u>  |         |  |  |   | 22e. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD</u>                               |   |  |                                |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |                                |                                   |
| <u>Interment</u>  |         | <u>6/5/68</u>  |  | <u>Jester ville Cem</u>   |   | <u>Jester ville, Md.</u>  |  |                                |                                   |
| 24. FUNERAL DIRECTOR <u>E. J. Messing, Biville, Md</u> ADDRESS  |         |  |  |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |                                |                                   |
|   |         |  |  |   | DATE <u>JUN 4 1968</u>  |   | <u>Charles Judge</u>   |                                |                                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |                              |   |  |  |
|--|--|--|--|---|--|---|--|--|------------------------------|---|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |                              |   |  |  |
| 1. DECEASED-NAME (Type or print) <i>Joseph Allan Yerby</i>   |  |  |  |   |  | 2a. DATE OF DEATH<br>Month <i>June</i> Day <i>25</i> Year <i>1968</i>                           |  |  | 2b. HOUR<br><i>3:40 P.M.</i> |   |  |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>CAUCAS.</i>  |  | 5. DATE OF BIRTH<br><i>10-18-96</i>   |  | 6. AGE (In years last birthday)<br><i>72</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |                              | IF UNDER 24 HRS.<br>HOURS MIN.                                |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Neumco</i>   |  |  | Md.                          |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Salisbury</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Wicomico Nursing Home, 3006 St. Salisbury</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Retired Carpenter</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Carpenter</i>   |  |  |                              |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><i>MD</i>   |  | 13b. COUNTY<br><i>Neumco</i>   |  | 13c. CITY OR TOWN<br><i>Delmar</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>309 Elizabeth St.</i> |                              |   |  |  |
| 14. FATHER'S NAME First <i>Thomas</i> Middle <i>Yerby</i> Last <i>Schwartz</i>   |  | 15. MOTHER'S MAIDEN NAME First <i>Cora</i> Middle <i>Schwartz</i> Last <i>Schwartz</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><i>169-20-6176</i>  |  | 17. INFORMANT<br><i>Mr. Doty Lawrence</i>          |                              | Address<br><i>Delmar Del</i>                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4109 Congestive heart failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i><br>(b) <i>Myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>2 mos.</i> |  |  |  |   |  |   |  |  |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 mos.</i> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>generalized arteriosclerosis</i>  |  |  |  |   |  |   |  |  |                              |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |                              |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |                              |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |                              |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/25, 1968</i> , to <i>6/25, 1968</i> , that (I) (we) last saw the deceased alive on <i>6/24, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |                              |   |  |  |
| 22b. SIGNATURE<br><i>William J. Mord</i>   |  | DEGREE<br><i>MD</i>  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED<br><i>6/26/68</i>  |  |  |                              |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>William J. Mord</i>   |  | 22e. ADDRESS<br><i>Salisbury Md.</i>   |  |   |  |   |  |  |                              |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>6/21/68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn C.</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore Baltimore Md</i>                  |  |  |                              |   |  |  |
| 24. FUNERAL DIRECTOR<br><i>William J. Mord</i>   |  | ADDRESS<br><i>Delmar Del</i>   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><i>JUN 27 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |                              |   |  |  |

